Missouri
State Board of Nursing Newsletter

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Message from the President

Rhonda Shimmens, RN-C, BSN, MBA

I am honored to have recently been elected as the President of the Missouri State Board of Nursing. I have been a member of the Board since 2009, and for the past two years served as Vice-President. I would like to recognize and thank Dr. Roxanne McDaniel for her exceptional leadership these past two years, and for her continued role on the Board.

The mission of the Missouri State Board of Nursing is to protect the public by the development and enforcement of state laws governing the safe practice of nursing. I look forward to the opportunity to serve as an advocate for this mission, and to represent Missouri as a delegate at the National Council of State Boards of Nursing.

License Renewals

At our September 2014 meeting, the members of the Missouri State Board of Nursing discussed whether to change the nurse licensure renewal expiration dates. The Board decided not to make a change at this time. I extend sincere gratitude to all of you that took the time to share your opinions with the Board. We will continue to collect input and revisit this issue at a later time. If you would like to comment about this issue, please send the Board an email at renewals@pr.mo.gov. We will keep you updated in our newsletter and on our web site.

Nursys E-Notify®

You now have a way to receive automated license and discipline notifications on yourself and/or nurses you employ. Nursys E-Notify® allows you as an individual nurse to enroll yourself so you can receive automated license expiration reminders and discipline status updates. This is a great way to make sure you keep your license active and guard against someone else using your license. You can do this by going to www.nursys.com, click on *Add Nurse to e-Notify*, and then click on *Register as a Nurse.*

If you employ nurses, you can track the license and discipline status of your employees by going to www.nursys.com and clicking on *Register as an Employer.* You will receive license expiration email reminders the first of every month. Reminders will include all licenses that expire the next month. For example, on March 1st, you would receive an email reminder that lists all licenses that will expire April 30th. You have the option of having the system send individual reminders to each nurse on that list to the nurse's email account or a text message to a telephone number.

Protect yourself by registering yourself as a nurse and protect your employer by registering your employees.

Telehealth Regulations

House Bill 315 passed during the 2013 regular legislative session. The bill removed geographic limitations for Advanced Practice Registered Nurses (APRNs) practicing in collaborative practice arrangements in rural areas of need if they were utilizing telehealth in the care of the patient. That bill required the Board of Registration for the Healing Arts (Healing Arts) and the State Board of Nursing (Nursing) to promulgate rules to establish the Utilization of Telehealth by Nurses.

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Executive Director's Report

Authored by Lori Scheidt, Executive Director
Missouri State Board of Nursing Elects Officers

The Missouri State Board of Nursing elected Board officers at their September 5, 2014, meeting.

Rhonda Shimmens was elected President. Ms. Shimmens is the manager of outpatient surgery at St. Mary's Health Center in Jefferson City. She holds a bachelor and associate degrees in nursing and a MBA with an emphasis in health management from William Woods University. She has served on the Board since April 2009.

Kelly Scott was elected Vice-President. Ms. Scott is a certified family nurse practitioner at the University of Missouri Health Care – Pediatric Orthopedics. She earned her Master's in Nursing from the University of Missouri.

Lisa Green was re-elected as Secretary. Lisa Green is a nurse educator who holds a Master of Science in Nursing and has an extensive nursing practice and nurse educator career.

2014 Fiscal Year Statistics

The 2014 fiscal year for Missouri State government began July 1, 2013 and ended June 30, 2014.

The Board reviews complaints that are filed against the license of a nurse. Following an investigation, the Board determines whether or not to pursue discipline. The Board may impose censure, probation, suspension, and/or revocation.

The Board of Nursing may take disciplinary action against a licensee for violation of the Nursing Practice Act (see 335.066, RSMo). The Board is authorized to impose any of the following disciplines singularly or in combination:

- Censure – least restrictive discipline. The imposition of censure acts as a public reprimand that is permanently kept in the licensee's file.
- Probation – places terms and conditions on the licensee's license.
- Suspension – requires that the licensee cease practicing nursing for a period not to exceed 3 years.
- Revocation – most restrictive discipline. The imposition mandates that the licensee immediately lose his/her license and may no longer practice nursing in Missouri.

The following charts show the category and source of complaint and application reviews that were closed this past fiscal year. There were 2,153 Board disciplinary decisions made in fiscal year 2014.

Executive Director's Report continued on page 2

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Important Telephone Numbers

Department of Health & Senior Services (nurse aide verifications and general questions)	573-526-5686
Missouri State Association for Licensed Practical Nurses (*MoSALPN*)	573-636-5659
Missouri Nurses Association (*MONA*)	573-636-4623
Missouri League for Nursing (*MLN*)	573-635-5355
Missouri Hospital Association (*MHA*)	573-893-3700

Number of Nurses Currently Licensed in the State of Missouri

As of October 1, 2014

Profession	Number
Licensed Practical Nurse	23,407
Registered Professional Nurse	101,874
Total	**125,281**

http://pr.mo.gov

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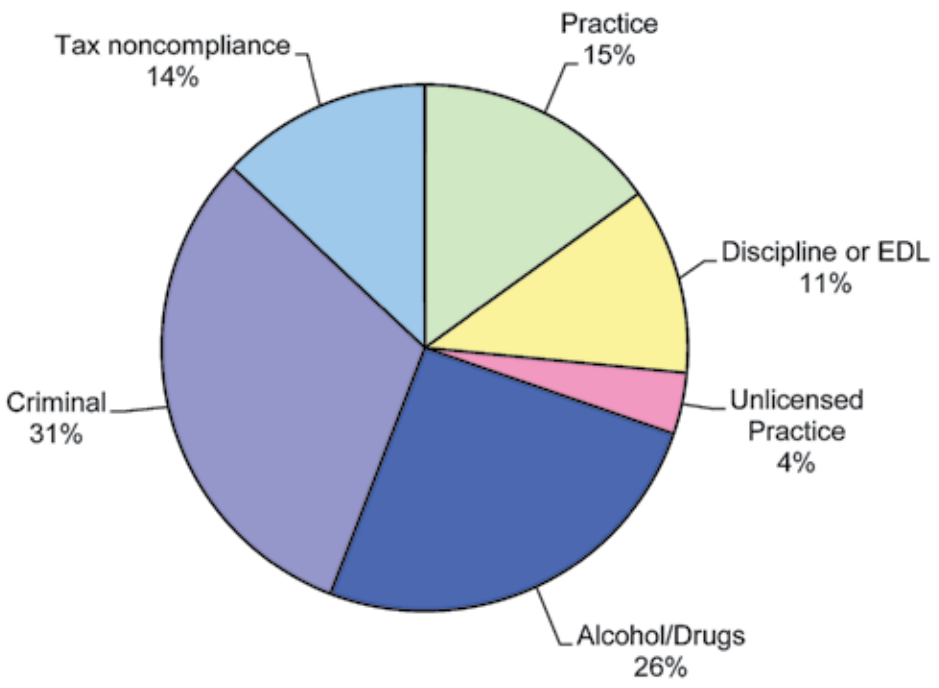
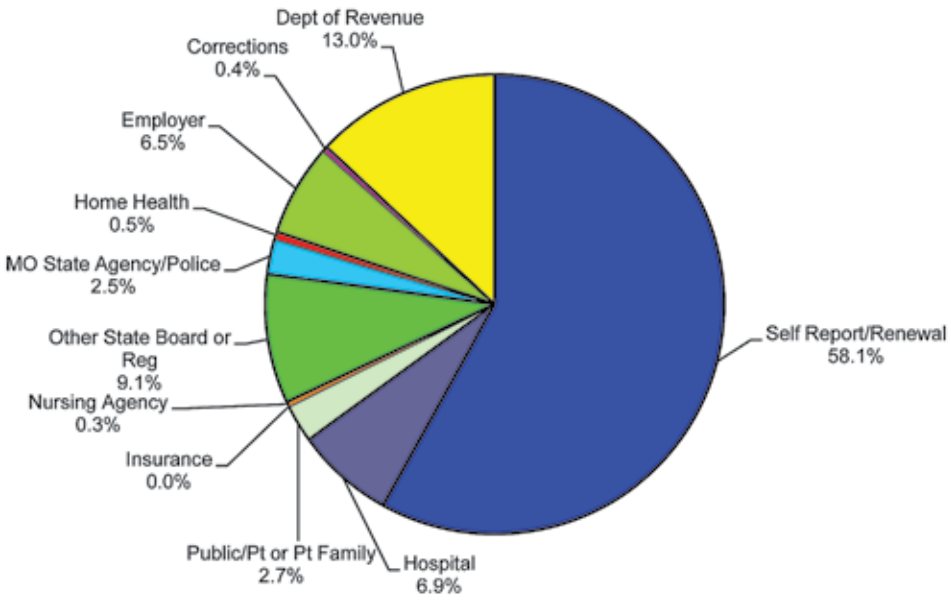
Complaint Categories FY 2014

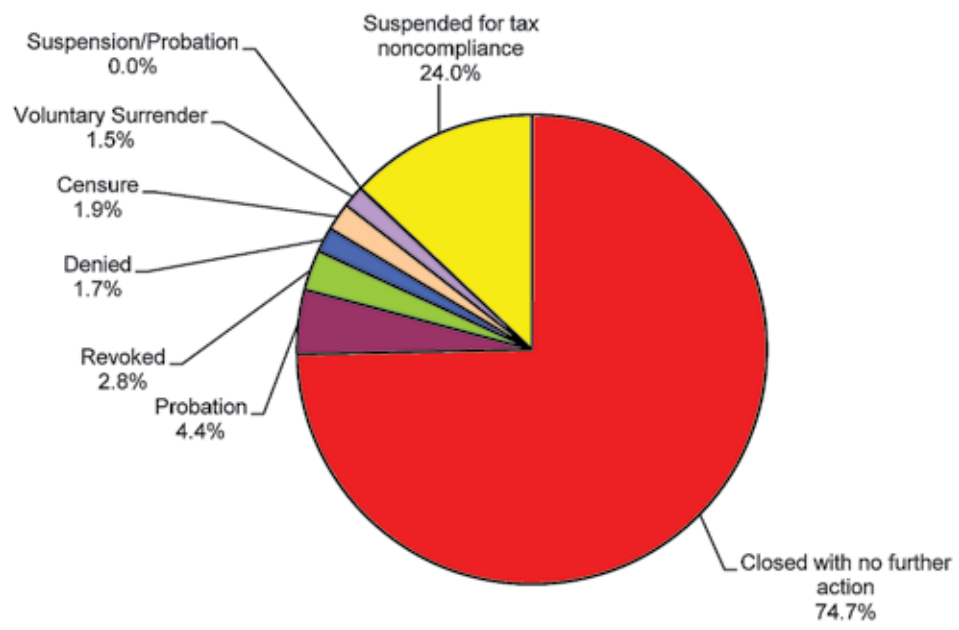


Closed Complaints By Source FY 2014



The next chart shows the actions taken by the Board for those complaints and application reviews.

Final Actions FY 2014



Licenses Issued in Fiscal Year 2014		
	Registered Nurse	**Licensed Practical Nurse**
Licensure by Examination (includes nurses not educated in Missouri)	3,851	1,319
Licensure by Endorsement	1,729	214
Licensure by Renewal of a Lapsed or Inactive License	1,389	306
Number of Nurses holding a current nursing license in Missouri as of 6/30/2014	99,780	22,406

There were 768 new Advanced Practice Registered Nurse applications approved in fiscal year 2014.

The Board granted 199 nurses advanced prescriptive authority in fiscal year 2014.

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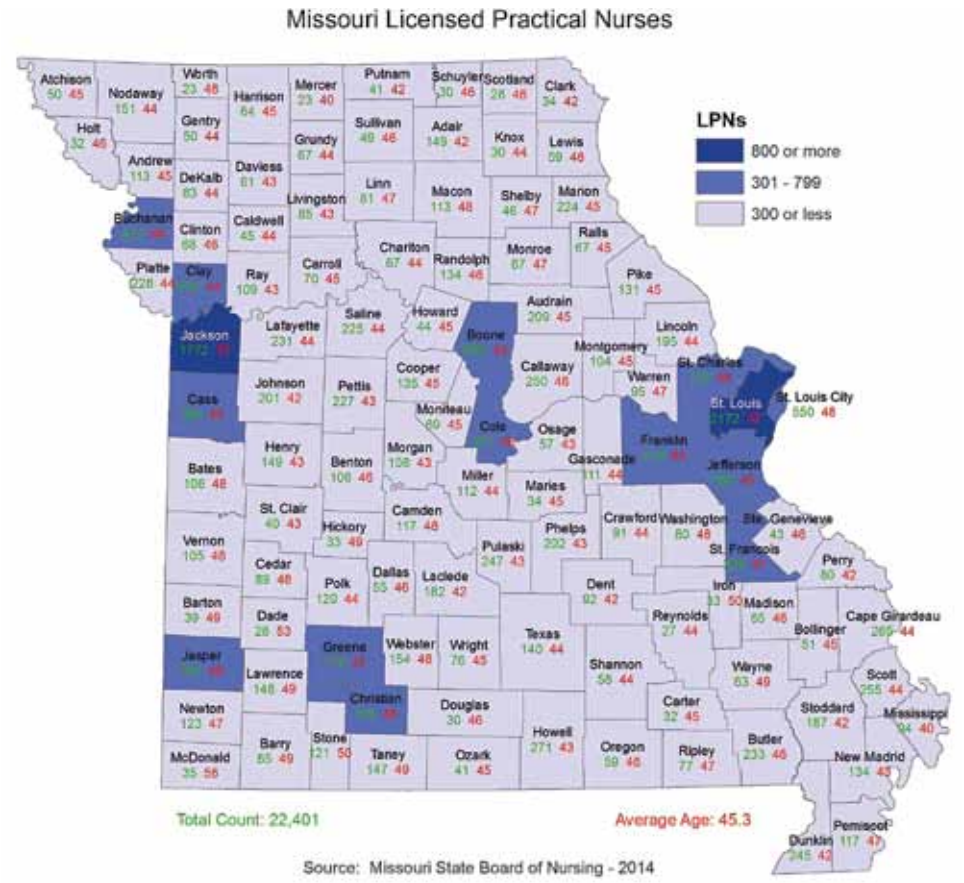
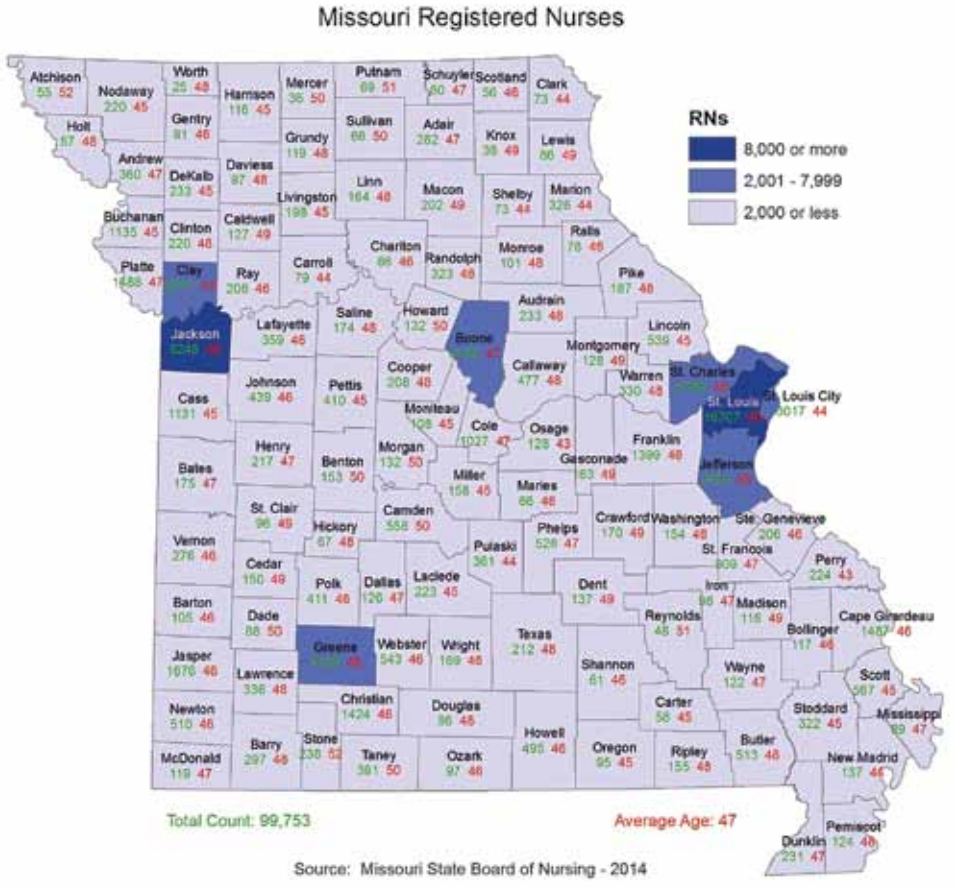
Licensure Database Information

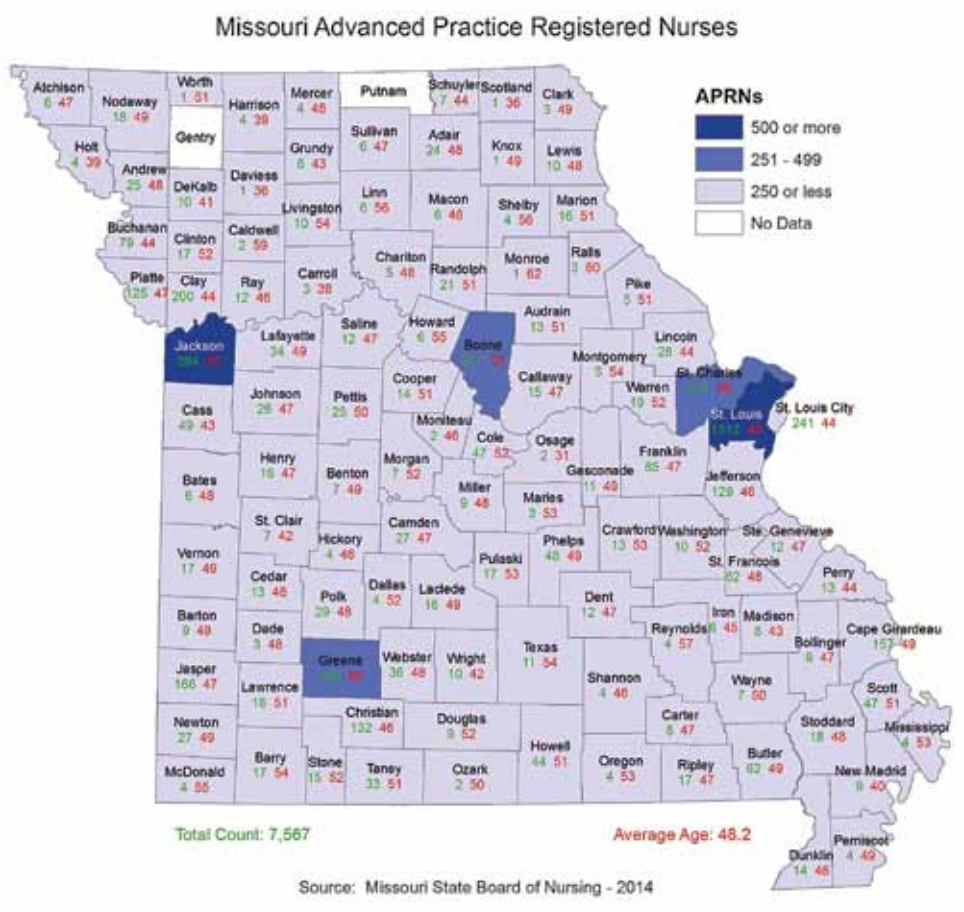
The average age of nurses continues to stay about the same. This is based on all nurses licensed in Missouri, regardless of where they reside.

Profession	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
RN	45	46.12	46.28	46.35	46.62	46.6	47.1	46.5	46.60	46.50	46.84
LPN	44	45.13	45.36	45.00	45.32	45	45.7	45.1	45.69	45.97	46.07
APRN									47.73	47.63	47.70

The following three maps depict the average age by county and the number of nurses in each county who had a current Missouri nursing license and Missouri primary address as of July 1, 2014. The average age on the following maps is the average age of nurses that reported Missouri primary residence.







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Telehealth is defined in §335.175.2, RSMo, as "the use of medical information exchanged from one site to another via electronic communications to improve the health status of a patient, as defined in section 208.670."

On September 10, 2013, a collaborative task force committee of the Board of Nursing scheduled a conference call with a collaborative task force committee of the Board of Registration for the Healing Arts to discuss how best to proceed with drafting and promulgating regulations to implement telehealth practice by nurses in rural areas of need as directed by House Bill 315. The Board of Nursing determined that more knowledge was needed regarding the needs for telehealth use in rural areas from those who are actually working in rural areas or are utilizing telehealth to provide health care. The Board of Nursing determined that three (3) experts in that field were needed to provide guidance. On September 13, 2013, Board staff began collecting resumes. On September 23, 2013, the Board of Nursing held a conference call and voted to choose experts from the resumes received to provide the Board with more information on the needs for utilizing telehealth in rural areas. The Board selected Patty Sohn, Carol Greening, Kelly Casler, JoAnn Franklin and Parvin Barouzi as task force members. They along with staff member Debra Funk and Board members Kelly Scott, Mariea Snell and Roxanne McDaniel comprised the Board of Nursing's telehealth task force. The Board of Nursing expresses its sincerest appreciation and gratitude to Patty Sohn, Carol Greening, Kelly Casler, JoAnn Franklin and Parvin Barouzi for committing their time and expertise to this work. They have proven to be very knowledgeable advanced practice registered nurses who have a wealth of knowledge in collaborative practice, advanced practice and telehealth.

Between September 2013 and December 2013, the Telehealth Task Force, some Board of Nursing members and staff visited telehealth facilities to gain a broader understanding of how telehealth is utilized. Staff from both Boards also continued to have conversations from September through December 2013.

During these meetings, the two Boards were in agreement with all but one provision of the rules.

Between January 2014 and September 2014, both Boards have had several meetings, both separately and jointly, to work on proposed rules.

The Boards agreed on language in two provisions of the current collaborative practice rules.

Both Boards agreed to amend 20 CSR 2150-5.100(2)(B) and 20 CSR 2200-4.200(2)(B) to indicate that no mileage limitation applies if the APRN is providing services pursuant to §335.175, RSMo and is practicing in a federally-designated health professional shortage area (HPSA).

Both Boards also agreed to amend 20 CSR 2150.5100(4)(F) and 20 CSR 2200-4.200(4)(F) to clarify that the broad range of telehealth (telephone, fax, email, video, etc.) is available for physicians to meet the requirement of being present for sufficient periods of time, at least every two weeks, to review and provide necessary medical direction, medical services, consultations, and supervision of health care staff. Again, this only applies if the APRN is providing services pursuant to §335.175, RSMo.

The challenge rested with 20 CSR 2150-5.100(4)(H) and 20 CSR 2200-4.200(4)(H). In the current regulations, it indicates that if an APRN provides health care services for conditions other than acute self-limited or well-defined problems, the collaborating physician, or other physician designated in the collaborative practice arrangements, shall examine and evaluate the patient and approve or formulate the plan of treatment for new or significantly changed conditions as soon as practical, but in no case more than two (2) weeks after the patient has been seen by the APRN or RN. The Board of Healings Arts advocated that this examination and evaluation must be conducted either via live, interactive video or in person.

The Board of Nursing believed that the proposal approved by the Board of Healing Arts was more restrictive than the statute. The Board of Nursing submitted several counter proposals which would allow the collaborative physician to determine how the examination and evaluation would occur.

A joint meeting between both regulatory boards was held on September 9, 2014. General Counsel for both Boards provided legal research and oral presentations on their respective Board's opinions and rich dialogue ensued between the Board members and with interested guests.

Two of the bill sponsors were also in attendance and iterated that passage of House Bill 315 did not change the collaborative practice requirements, nor was it the intent to eliminate the two week follow up examination.

At the end of the meeting, the Board of Nursing agreed to the Board of Registration for the Healing Arts' proposal. The following is the statement prepared by the members of the Missouri State Board of Nursing and part of their official decision.

"We see this as a lost opportunity to make changes to the regulation in order to improve access to quality healthcare.

"We understand the political implications of us not agreeing, and we continue to maintain the regulations are more restrictive than statute.

"In the spirit of cooperation, we will accept the Board of Healing Arts' proposal. We hope to continue communication regarding collaborative practice to improve access to quality healthcare for all Missourians.

"We also want to take this time to thank Representative Kathryn Swan for committing her time and energy for not only sponsoring this legislation but for working with both Boards."

The next step is to file the proposed rules with the Secretary of State's office. Rules are initially printed in the *Missouri Register*, which is published twice a month by the Secretary of State's office. Once a rule has been published, a 30-day comment period begins during which any member of the public may provide written comments to the agency promulgating the rule. The agency must compile the comments received on the rule as well as any changes to be made to the text of the rule as a result of the comments received in an Order of Rulemaking. The Order of Rulemaking is then filed with the Joint Committee of Administrative Rules and may not be filed with the Secretary of State until 30 days have elapsed. The Joint Committee on Administrative Rules may convene hearings on rules as it deems necessary, but generally holds hearings in the 30 day period in which the Order of Rulemaking is on file with the committee. Typically the committee will convene a hearing upon the request of any member of the committee or upon request of the five members of the General Assembly. Citizens may also request the committee to convene a hearing. At a hearing, the committee will hear testimony from those opposing the rule as well as those who are supportive of the rule, including the state agency responsible for promulgating the rule. Thereafter, the committee may take action on the rules and may disapprove the entire rule or any portion thereof. If the rule is disapproved by the committee, it is held in abeyance and may not be published by the Secretary of State. For the committee's disapproval to become permanent, the General Assembly must ratify the action of the Joint Committee on Administrative Rules.

If no hearing is held by the Joint Committee on Administrative Rules, the Order of Rulemaking is then filed with the Secretary of State who then publishes the Order of Rulemaking in the *Missouri Register*. The rule is then printed in the Code of State Regulations, which is published monthly. The rule goes into effect 30 days after publication in the Code of State Regulations.

You can sign up to receive email notifications of revised or new rulemakings through the Secretary of State's office at www.sos.mo.gov. Information about the Joint Committee on Administrative Rules may be found at http://www.senate.mo.gov/jcar/.

At the conclusion of the September 9, 2014 joint meeting, both the Board of Nursing and Board of Registration for the Healing Arts agreed to continue dialogue about collaborative practice and joint regulatory issues. Representative Kathryn Swan has also agreed to continue to facilitate dialogue with both Boards.

Moments with Marcus

"Just Nurses"

by Marcus Engel

During Hospitals Week in May I was keynoting for a session, which, I thought, was an invite only presentation for docs. Turns out, a decision had been made to invite not just docs, but everyone from the hospital. Awesome! The more, the merrier!

Before the presentation started, three ladies made their way into the empty auditorium. I always like to go meet folks before I keynote, so off I went to introduce myself.

After we'd exchanged names, I asked, "So, what is your area of practice?" Keep in mind, I still thought this session was physician only. The response was informative... but made me a little sad.

"Oh, Marcus, none of us are doctors. We're just nurses."

"Just" nurses?

Nurses... those professionals who probably log more hours with patients than any other employees in the whole institution? Those who are members of the most trusted profession in America? Those individuals who are there to provide expert skills, compassion and support during the most vulnerable moments of a patient's life?

"Just" nurses?

I found their use of the J word a bit perplexing. My interpretation was that they did not see themselves as vital as doctors. They seemed to take on an air of "less than" since they didn't have M.D. or D.O. after their names.

Nurse friends, if you work in a health care environment, there is no "just" anyone. Yeah, there's this system of hierarchy in the hospital, just like there is in greater society. It exists, we all know it, move on. Yet, when these ladies described themselves as "just," it felt like they were putting themselves in a lower category. That, "Aw, shucks," eyes glancing at the floor thing where one's body actually seems to shrink a bit at feelings of lower self-worth. To this I say, "Bunk!"

Nurses are THE essential caregivers. They are the spokes in the wheel that gives health care the momentum to propel patients to healing. You, nurses, are those who spend the greatest amount of time with patients and provide the most support in their return to health.

You are a nurse! Be proud of that! I mean REALLY proud! You do an incredibly tough job, day in and day out. It is a job that can leave you physically, mentally, emotionally and spiritually worn down to nothing at the end of a shift. It can also lead to the most incredible, humbling and life affirming experiences. Sometimes on the same shift!

If you've ever gotten off work and sat in your car and had a good, ugly cry before going home, you're doing it right. When all you want is to be alone and curled up in a ball for hours, and you still walk into the next patient's room with a smile, that's when you're doing it right. When you go home and can barely drag yourself to bed, that's when you're doing it right. And I know that, for most everyone reading this, that is exactly what you do. You are not "just" anyone! Be proud, nurses, you are doing it right!

Marcus Engel really likes nurses! He's also the author of "The Other End of the Stethoscope" and "I'm Here: Compassionate Communication in Patient Care." Marcus speaks, writes and lives to provide insight and strategies for excellent patient care. MarcusEngel.com and ImHereMovement.org is where you can find him.

Education Report

Authored by Bibi Schultz, RN MSN, CNE
Education Administrator

Missouri State Board of Nursing (MSBN) Education Committee Members:

- Roxanne McDaniel, RN, PhD (Chair)
- Lisa Green, RN, PhD(c)
- Mariea Snell, MSN, BSN, RN, FNP-BC

Transition to Practice –
Responsibility of Education or Practice?

With implementation of the Affordable Care Act the full impact on nursing shortages is at best unclear at this time. What we do know is that while our population is aging so are our nurses. A survey conducted by the National Council of State Boards of Nursing and The Forum of State Nursing Workforce Centers indicates that in 2013, 55% of the RN workforce across the country was 50 years old or older. Nationally, recent market analyses show that health care related jobs continue to lead the employment market. The Missouri Hospital Association (MHA) 2013 Workforce Report references U.S. Bureau of Labor Statistics data that projects a national health care related job growth of 20,000 by June 2013. The U.S. Bureau of Labor Statistics projects that by 2022, the total number of job openings for nurses across the country will rise to 1.05 million.

It is clear that our aging population is currently dependent on an equally aging workforce to provide necessary care. While economic impact is projected to have kept many nurses from retiring, the need for nurses, especially in more rural areas of the State, continues to grow. MHA workforce data indicates 2013 nurse vacancy rates in Missouri of up to 9.8%. While nursing schools across the country strive to increase enrollment, transition to practice is seen as a pivotal point in retaining nurses at the bedside. According to American Association of Colleges of Nursing (AACN) data, published in their 2012-2013 Enrollment and Graduation in Baccalaureate and Graduate Nursing Program report, baccalaureate and graduate level nursing programs across the country turned away 76,659 qualified applicants. AACN reports that Missouri baccalaureate and graduate level nursing programs enrolled a total of 10,933 students in 2013. While it is reported that 3,240 students graduated from Missouri BSN and graduate level nursing programs that same year, these schools also turned away 3,171 qualified applicants during this time frame. Shortage of qualified faculty and lack of opportunities for clinical placements are major barriers to expand enrollment. National Council of State Board of Nursing (NCSBN) data for 2013 indicates that 3,201 graduates from Missouri pre-licensure professional nursing programs passed the NCLEX-RN licensure exam on the first attempt (87.17%). Data also reflects that 1,265 graduates from Missouri pre-licensure practical nursing programs passed the NCLEX- PN licensure exam on the first attempt as well. Missouri first-time licensure exam pass rates continue to exceed national levels by significant margin (U.S. RN for 2013 = 83.04%; U.S. LPN for 2013 = 84.63%).

While nursing school enrollment and graduation rates from professional nursing programs show steady increase, growing complexity of the health care environment and often unrealistic expectations of new graduates and employers wreak havoc with transition to nursing practice and staff retention. New nurses often report that they leave the bedside disillusioned and frustrated with challenges they feel ill-prepared to meet and/or demands that are out of their realm of expectation. Acute care environments seem especially impacted by frequent nurse turnover. Responsibility to prepare new nurses to safely care for patients, to optimally transition to clinical practice and function efficiently and comfortably in their new habitat has become a great point of discussion. Orientations are often insufficient to meet the new employee's needs and monies spent seem wasted when nurses leave after just a few months of employment. The Missouri Hospital Association (MHA) 2013 Workforce Report sheds some light on current job retention data for nurses employed by Missouri hospitals. While this data is not limited to new graduates, it provides some insight on the struggle to retain nurses in acute care settings. Average RN turnover rate for 2013 is reported at 10.2%; for LPNs it is even higher at 14%. Nurse Practitioner turnover data indicates a rate of 9.3%.

The goal is to optimally prepare graduates to make a smooth transition from novice practitioners prepared for entry-level practice to more advanced beginners and then to evolve to competent, comprehensive practitioners as professional nurses. Many nurses experience what is frequently described as rather bumpy transitions. Responsibility to ease this transition is debated between schools and work settings. Nursing schools carry responsibility to prepare students and graduates for nursing practice. Minimum Standards, Missouri State Board of Nursing rules in place to regulate pre-licensure

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nursing programs, clearly iterate requirements to provide learning experiences that facilitate transition to practice. Curriculum requirements include content related to use of information technology to communicate, manage knowledge, mitigate error and support decision making; employment of evidence-based practice to optimize care; consideration of moral, legal and ethical standards to guide clinical decision making; understanding quality improvement to measure patient outcomes; and identification of hazards and errors to bring about positive change in patient care are just a few examples of required content matter. Clinical learning plays a significant role in preparation and transition to practice. While students have shared responsibility in the care of patients since the beginning of nursing education, opportunities for clinical learning seem to dwindle. In many cases clinical sites are overwhelmed with large numbers of students that schools are trying to place and mounting practice liabilities further complicate the picture. Out-of-state clinical placements also place additional constraints on availability.

The majority of nursing programs at all levels of pre-licensure nursing education have implemented some level of simulation to enhance exposure to essential clinical situations. Nurse educators innovatively create sophisticated clinical scenarios that allow students to work through complex care situations, to enhance clinical decision making and to think globally at the bedside. For many schools funding is insufficient to optimally support simulation. Not only is equipment quite pricy, often opportunities for faculty development are insufficient to keep pace with advancements in technology. Some of the larger schools share opportunities for area nursing programs to use their resources to enhance learning for their students. The idea that all nursing schools could attain and maintain expensive simulation resources, keep their faculty abreast on developing technology and be ready to continuously provide cutting edge experiences is unrealistic and would reflect unnecessary duplication of resources, preparation and services. Ideally, schools and clinical settings form partnerships to share resources, enhance learning and foster professional development for students, graduates, faculty and staff. While many such partnerships have been developed and additional ones are emerging, many more are needed to empower faculty and staff to work with their colleagues from other health professions to collaboratively prepare students and nurses.

Many nursing programs require students to complete capstone assignments as part of final semester course work designed to immerse them in concentrated clinical experiences in selected patient care settings. Each student is placed with a clinical preceptor for extended periods of time to enhance exposure to actual practice as a nurse. Some clinical partners offer externships to nursing students to familiarize them with care settings, help to ease transition to practice and to assess skills for possible future employment. Once graduated, nurses may have the opportunity to complete nurse residency programs. Many of these programs come about through partnerships of clinical providers and nursing education programs with the intent to ease transition to practice, foster patient safety and to retain new nurses in roles essential to quality patient care. National nursing accreditations are now available for such programs to ensure that quality standards are met. Residency programs are expensive to operate and do not always yield expected outcomes.

With growing concentration on improved transition to practice and multiple efforts to make this happen, concerns related to preparation of new nurses to optimally meet challenges of today's complex health care environment continue. Readiness of nurses to provide safe, optimal care to patients should be at the forefront of decision making for nurses, schools and clinical partners. Enhanced collaborative efforts are necessary to bring about this change. In many settings residency programs are not available and even extensive orientation processes and assignments to clinical preceptors do not seem to ease transition. New nurses continue to leave the bedside. If this trend is allowed to continue, impact especially on high acuity acute care settings may be devastating. Patient safety data continues to indicate the need to put and keep systems in place to ensure protection of patients. Growing health care needs promise to complicate this situation. So what can and should be done? Who is responsible to ensure transition to practice and to safeguard preparation to provide safe care?

Responsibility begins with nursing programs to ensure appropriate preparation of students in theory and clinical. This begins with careful assessment of potential to successfully complete the nursing program, appropriate progression of content to ensure that graduate competencies are consistently attained and graduates are optimally prepared for entry-level clinical practice. While schools should provide sufficient learning experiences, so much of learning depends on motivation of each student to immerse in clinical learning and to personally invest in preparation to practice. Faculty must be vigilant to ensure that students are appropriately counseled, program expectations and standards remain strong and are enforced, and outcome criteria are consistently met.

When approaching employment as a new nurse, graduates should be prepared to provide employers with information that helps to determine essential educational needs. Development of clinical portfolios while in school to provide insight about clinical exposure may streamline orientation, identify essential learning needs and guide employers in determination of clinical assignments for new graduates. New nurses must be prepared to practice safely and meet beginning challenges, but should never face complex care situations alone. New nurses share the responsibility to ensure that their first employer supports their learning, and offers extensive, well-designed orientation and mentoring opportunities. Graduate nurses must make sure that employers recognize the need for support to manage new challenges while providing safe and effective care for patients.

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Missouri Hospital Association. (2014). *Annual workforce report 2013.* Retrieved from http://web.mhanet.com/resources/workforce-and-staff- development/workforce-resources

U.S. Bureau of Labor Statistics. (2014). *Table 9. Employment and total job openings by education, work experience, and on-the-job training category, 2010 and projected 2020.* Retrieved from http://www.bls.gov/news.release/ecopro.t09.htm

Schedule of Board Meeting Dates through 2016

November 19-21, 2014
March 4-6, 2015
June 3-5, 2015
September 2-4, 2015
December 2-4, 2015
March 9-11, 2016
June 1-3, 2016
September 7-9, 2016
December 7-9, 2016

Meeting locations may vary. For current information please view notices on our website at http://pr.mo.gov or call the board office.

If you are planning on attending any of the meetings listed above, notification of special needs should be forwarded to the Missouri State Board of Nursing, PO Box 656, Jefferson City, MO 65102 or by calling 573-751-0681 to ensure available accommodations. The text telephone for the hearing impaired is 800-735-2966.

Note: Committee Meeting Notices are posted on our web site at http://pr.mo.gov

Missouri Department of Health and Senior Services

DEA Reschedules Hydrocodone Products to Schedule II:

The United States Drug Enforcement Administration (DEA) has announced they are re-scheduling hydrocodone drug products from Schedule III into Schedule II. The final rule was published in the Federal Register on August 22, 2014. The new rule goes into effect on October 6, 2014, at which time the handling of all hydrocodone products including but not limited to handling, labeling, and dispensing must comply with the requirements for Schedule II controlled substances. Prescriptions that were issued before October 6, 2014, while the drug products were still in Schedule III, may have their refills honored and dispensed. The dispensing on these refills cannot go past their 6 month date in April 2015. Additional information for the rescheduling of hydrocodone is available at the DEA website www.deadiversion.usdoj.gov.

Rescheduling of Hydrocodone Products in Missouri:

The dispensing and prescribing laws in Missouri are not in a regulation that the BNDD can amend. The dispensing limits are set in statute, Section 195.060.1, RSMo, which states that no Schedule II prescriptions may be refilled.

New DEA Rules for Disposing of Unwanted Controlled Substances:

The DEA published their final rule for the disposal of controlled substances in the *Federal Register* on September 9, 2014. This new rule goes into effect on October 9, 2014.

The BNDD is reviewing state laws relating to controlled substances to determine the effect of the new federal regulations. Registrants should consult their legal counsel for questions with state controlled substance laws and the registrants' practice acts as well as federal controlled substance laws.

Please note, that § 195.070, RSMo, prohibits practitioners from accepting unused controlled substances from patients unless the practitioner originally dispensed the drug.

Goodbye!

by Becki Hamilton, Executive Assistant

In late 2000, my husband and I moved from California to Missouri to be closer to family. After settling into our new home, I started looking for a job. I was blessed to find a job working for the Missouri State Board of Nursing, but now almost 14 years later it is time for me (and my husband) to retire and seek new adventures!

I have really enjoyed working for the Board. There always seems to be something new happening and another project to do. Over the years that I have worked for the Board there have been four Governors, four Division of Professional Registration Directors, nine Board of Nursing Presidents, two Executive Directors and numerous staff changes.

Looking back, I found that there were a number of changes including:

- A new licensure system had just been implemented in 1999 to make us Y2K compliant! We moved from saving records on microfiche to saving records on an imaging system. Next year the Division will be implementing an updated licensure system which will allow the license record to be connected to the imaged licensee file to better serve the needs of the Professional Registration boards.
- Just prior to my arrival at the Board, the Board contracted with Arthur L. Davis Publishing Agency to publish our quarterly newsletter. Even the newsletter now has a different look than when I first started.

- The Nurse Licensure Compact – In 2000, just 8 states were part of the compact. We joined the compact in 2009 and now there are 24 states that are part of the compact.
- When I started, there were a number of contract investigators that processed the complaints received. This system was revamped and internal investigators were hired and most of the investigations are now conducted via telephone. The resulting cost reduction and increase in productivity resulted in receipt of the Governor's Award for Quality and Productivity in 2004.
- Licenses were printed on paper when they were issued. In 2005 we began issuing a credit card type license.
- Verifications of licensure have evolved. Licensure could be verified on the website as early as 2001 but the information was only updated weekly until 2004 when it was updated every night. In 2013, Nursys e-Notify became available which provides notification whenever a license status changes.
- Since background checks were required for licensure, the licensure group had to learn how to take fingerprints for nurses applying for licensure that came into the office. We needed to have wet wipes handy! Today, fingerprints are processed by first registering at www.machs.mo.gov and then going to a fingerprint site to have the prints taken.
- Rather than sending out renewal applications, the Board now mails out renewal post cards and encourages online renewal.
- The number of active nurses (RNs and PNs) in Missouri shortly after I started was 94,928. This number has increased and decreased over the years, but as of now it is 124,521, which is over 30,000 more than it was in 2001.
- When I started the Board used the services of the Attorney General's office to conduct the hearings before the Board. In 2008, the Board hired an in-house attorney and a paralegal. Since that time we have added two additional in-house attorneys and two more paralegals. The use of in-house attorneys has increased productivity by allowing the attorneys to focus on the work of the Board.

Some of my favorite things I've been involved in over the years include the following:

- The implementation of the Golden Awards which are sent each year to those that have been active nurses in Missouri for 50 years. I have enjoyed receiving nice letters of appreciation from those receiving this honor.
- Working with the Springfield News Leader to determine the winners of their annual Salute to Nurses awards.
- "Sleuthing" – on a number of occasions, I've enjoyed doing a bit of sleuthing by
  - o exploring the history of the Board of Nursing and presenting the information in the 100-year anniversary edition (11/2009) of the quarterly newsletter
  - o finding contact information of individuals for class reunions
  - o returning some 1930s nursing mementos, that were sent to the Board, to the family of the nurse to whom they belonged
  - o completing a very long project of sealing records in cases against a license where no disciplinary action was taken by the Board
- Regulatory Achievement Award – The Board was presented with the Regulatory Achievement Award by the National Council of State Boards of Nursing in August of 2012. I was privileged to be present when the award was given.

As you can see, many things have happened over the last fourteen years and I am grateful to have had this opportunity to learn and grow at the Missouri State Board of Nursing. It has been wonderful working with Executive Director, Lori Scheidt. I admire her passion for patient safety and her ability to think outside the box. I will miss her, the Board members and all of my co-workers.

As for those new adventures, no I am not planning to sell everything and go traveling across the country in a motor home, but I am looking forward to creating more hand-made greeting cards, doing some volunteer work, spending more time with my four grandchildren and just having some time to relax and enjoy life without having to get up so early in the morning!

2014 Golden Awards

We are happy to announce that *Golden Certificates* were recently sent to 207 Registered Nurses and 32 Licensed Practical Nurses. These individuals have active licenses and have been licensed in the State of Missouri for **50 years**. We take great pleasure in marking this special achievement in the ninth year of our Golden Award Recognition program. A list of those receiving Golden Certificates follows.

LPN	Bernice Campbell	Cape Girardeau, MO
LPN	Karen F. Clapper	Raytown, MO
LPN	Patricia E. Enochs	Monroe City, MO
LPN	Geraldine Evans	Richmond Heights, MO
LPN	Joyce E. Fovell	Kansas City, MO
LPN	Bobrie E. Glenn	Florissant, MO
LPN	Lydia J. Hastings	Glenallen, MO
LPN	Elizabeth S. James	Saint Louis, MO
LPN	Linda A. Juarez	Imperial, MO
LPN	Louise S. Koonce	St. Ann, MO
LPN	Normal D. Lewis	Saint Louis, MO
LPN	Gearlene R. Luttrell	Sikeston, MO
LPN	Margaret P. Lybarger	Nixa, MO
LPN	Glenna M. Mathes	Maryville, MO
LPN	Judith Z. Meade	St. Joseph, MO
LPN	Shirley J. Murphy	Kansas City, MO
LPN	Gloria L. Niederschulte	Saint Ann, MO
LPN	Sylvia M. Nohr	Labadie, MO
LPN	Sandra S. Pence	Nevada, MO
LPN	Carol F. Peterman	St. Peters, MO
LPN	Janice T. Phillips	New Bloomfield, MO
LPN	Wilhelmina W. Robinson	Saint Louis, MO
LPN	Evelyn Ann Rugen	Independence, MO
LPN	Shirley L. Schmidt	Warrenton, MO
LPN	Yvonne V. Smith	Saint Louis, MO
LPN	Carol N. Sommers	Columbia, MO
LPN	Sandra L. Soroka	Saint Louis, MO
LPN	Sharon L. Stockton	Kansas City, MO
LPN	Judith A. Utterson	Saint Peters, MO
LPN	Jerilyn H. Watts	Independence, MO
LPN	Martha Wilson	Jackson, MO
LPN	Juanita B. Younger	Grandview, MO
RN	Elizabeth A. Adamson	Prairie Village, KS
RN	Judith A. Alexiou	Jefferson City, MO
RN	Celia C. Allman	Kearney, MO
RN	Ellen B. Alwood	Florissant, MO
RN	Betty S. Anderson	Monroe City, MO
RN	Frances Deanne Atkins	Higginsville, MO
RN	Suzanne B. Baremore	Battlefield, MO
RN	Beverly J. Bargfrede	Alma, MO
RN	Nancy K. Barr	Kansas City, MO
RN	Linda J. Bartley	Butler, MO
RN	Janice K. Bay	Washington, MO
RN	Judith S. Besch	Manchester, MO
RN	Mary R. Bock	St. Mary, MO
RN	Patricia E. Boehm Jaegers	Linn, MO
RN	Marjorie W. Bosman	Manchester, MO
RN	Dixie L. Boyce	Ballwin, MO
RN	Judith A. Brittain	Troy, MO
RN	Mary E. Brockmann	Valley Park, MO
RN	April D. Brown	Warsaw, MO
RN	Doris J. Brown	Republic, MO
RN	Martha L. Brown	Shawnee Mission, KS
RN	Evelyn M. Browner	New Bloomfield, MO
RN	Patricia A. Brush	Saint Louis, MO
RN	Barbara J. Buescher	Jefferson City, MO
RN	Maureen A. Burlew	Eastsound, WA
RN	Evelyn M. Butt	Marshfield, MO
RN	Marjorie A. Calender	Saint Louis, MO
RN	Maxine E. Callaghan	Saint Louis, MO
RN	Karol K. Carlson	Dunnegan, MO
RN	Judith Carron	Saint Louis, MO
RN	Diana R. Carter-myers	Columbia, MO
RN	Patricia K. Cerone	Saint Louis, MO
RN	Nancy J. Clark	Saint Louis, MO
RN	Vivian S. Coday	Mountain Grove, MO
RN	Caryl L. Collier	Jefferson City, MO
RN	Marvin T. Colyer	Farmington, MO
RN	Patricia O. Colyer	Farmington, MO
RN	Sheila G. Coonfare	Independence, MO
RN	Benola M. Cooper	Harvey, LA
RN	Annette N. Craddock	Overland Park, KS
RN	Anna M. Creech	Columbia, MO
RN	Anna J. Crockett	New Madrid, MO
RN	Peggy G. Daerda	Saint Louis, MO
RN	Mary E. Dana	Saint Louis, MO
RN	Janice L. Darby	Columbia, MO
RN	Elizabeth K. Darter	Kansas City, MO
RN	Betty G. Davies	Independence, MO
RN	Martha Charlene Dearing	Overland Park, KS
RN	Diane S. Dettwiler	Waterloo, IL
RN	Edna K. Dillingham	Kansas City, MO
RN	Sharon E. Dove	Springfield, MO
RN	Selma H. Dulany	Nixa, MO
RN	Marian R. Dunbar	Independence, MO
RN	Joan W. Duncan	Ballwin, MO
RN	Judith A. Ehrlich	Arnold, MO
RN	Georgia G. Ellis	Wentzville, MO
RN	Mary L. Emig	Shawnee Mission, KS
RN	Phyllis L. Fennell	Nixa, MO
RN	Connie J. Fitzhenry	Saint Louis, MO
RN	Sharon S. Fletcher	Smithville, MO
RN	Betty P. Forbes	Overland Park, KS
RN	Mariann Fox	Saint Louis, MO
RN	Virginia A. Fronick	Marthasville, MO
RN	Lola M. Fry	Seymour, MO
RN	Peggy Gadlin	Lomita, CA
RN	June E. Gallagher	Saint Louis, MO
RN	Janet K. Garoutte	Carl Junction, MO
RN	Barbara A. Gaydos	Chesterfield, MO
RN	Sharon K. Giboney	Springfield, MO
RN	Susan V. Gille	Maryville, MO
RN	Esther M. Gray	Cape Girardeau, MO
RN	Joyce B. Guess	Kansas City, MO
RN	Judith F. Guyn	Kansas City, MO
RN	Dorcas E. Hall	Mehlville, MO
RN	Linda H. Hall	Overland Park, KS
RN	Melba R. Hall	Harrisburg, MO
RN	Joan R. Hamilton	Frankford, MO
RN	Vera O. Haney	Hermann, MO
RN	John J. Hansmann	Poplar Bluff, MO
RN	Judy C. Hayes	Cincinnati, OH
RN	Sandra S. Heineman	Chesterfield, MO
RN	Carolyn L. Henning	Saint Louis, MO
RN	Dolores J. Herndon	Sweet Springs, MO
RN	Judith W. Hibbard	Arnold, MO
RN	Nancy A. Higgins	Springfield, MO
RN	Patsy J. Hill Dibben	Lebanon, MO
RN	Mary J. Hoffman	Grandview, MO
RN	Joan J. Hogrebe	Saint Louis, MO
RN	Kathleen E. Hollowood	Saint Louis, MO
RN	Joyce Holtmann	Saint Louis, MO
RN	Louellen M. Honeycutt	Monett, MO
RN	Jean E. Horrall	Roach, MO
RN	Donna A. Hostetter	Chesterfield, MO
RN	Mary A. Howe	Chesterfield, MO
RN	Rae H. Hubbert	Bolivar, MO
RN	Dorothy A. Hulett	Independence, MO
RN	Patricia A. Hultz	Springfield, MO
RN	Karen K. Inman	Springfield, MO
RN	Judith Y. Jacobs	Saint Louis, MO
RN	Patsy A. Johnson	Cameron, MO
RN	Loretta M. Jones	Mineral Point, MO
RN	Barbara J. Jozwiak	Saint Louis, MO
RN	Karen S. Kauffman	Chesterfield, MO
RN	Jeanne T. Kelly	Richmond Heights, MO
RN	Mary K. Kelly	Saint Louis, MO
RN	Sharon K. Kimbrell	Brookline Station, MO
RN	Teresa M. King	Kansas City, MO
RN	Marilyn Kay Kirkendall	Rolla, MO
RN	Mary E. Kliethermes	Jefferson City, MO
RN	Sharan L. Klingner	Springfield, MO
RN	Judy L. Kneebone	Harrisonville, MO
RN	Reva B. Koenig	St Charles, MO
RN	Jeanette D. Kowalski	Glen Carbon, IL
RN	Patricia J. Krippner	Saint Louis, MO
RN	Judith E. Kupferle	Ballwin, MO
RN	Rosemarie Lambrich	Saint Louis, MO
RN	Judith A. Langevin	Joplin, MO
RN	Jo Anne M. Lile	Gladstone, MO
RN	Myra L. Linville	Lees Summit, MO
RN	Kathleen M. Livingston	Waverly, MO
RN	Elizabeth L. Longi	Kirkwood, MO
RN	Carolyn L. Lonigro-Statler	Richmond Heights, MO
RN	Gloria A. Lounds	Belton, MO
RN	Opzerine D. Madison	Kansas City, MO
RN	Cynthia R. Manade	Independence, MO
RN	Dorothy A. Markiewicz	Saint Louis, MO
RN	Judy R. Martin	Blue Springs, MO
RN	Marilyn M. Mattas	Mt. Vernon, MO
RN	Donna K. Mccracken	Billings, MO
RN	Mary S. Mccullough	Trenton, MO
RN	Linda J. Mcelwee	Cowgill, MO
RN	Evelyn J. McEvoy	Saint Louis, MO
RN	Joanne L. Mcilvaine	Saint Louis, MO
RN	Lydia A. Meier	Des Peres, MO
RN	Norma M. Metheny	Ballwin, MO
RN	Jana R. Meyer	Saint Louis, MO
RN	Aleta P. Miller	Columbia, MO
RN	Vicki O. Miller	Independence, MO
RN	Karen J. Minkemann	Saint Louis, MO
RN	Carol J. Montgomery	Kansas City, MO
RN	Sandra Jeanne Moore	Stockton, MO
RN	Judith J. Mullins	Saint Charles, MO
RN	Janet O. Murman	O' Fallon, MO
RN	Constance H. Murphy	Hannibal, MO
RN	Peggy S. Musgraves	Saint Louis, MO
RN	Carol A. Myszak	Saint Louis, MO
RN	Patricia L. Nale	Camdenton, MO
RN	Mary L. Nauman	Maryland Heights, MO
RN	Mary E. Nelson	Overland Park, KS
RN	Linda S. Neptune	Overland Park, KS
RN	Janet J. Newman	Kansas City, MO
RN	Joyce M. Oberle	Sullivan, MO
RN	Mary E. Oden	Boonville, MO
RN	Sherry L. Padley	Parkville, MO
RN	Mary D. Payne	Lawrence, KS
RN	Stella M. Peterein	Festus, MO
RN	Patricia A. Peverly	Troy, IL
RN	Ruth M. Ploeger	Independence, MO
RN	Brenda Yarber Reid	Saint Louis, MO
RN	Margaret A. Reynolds	Saint Louis, MO
RN	Judith Ann Richardson	Sedalia, MO
RN	Carol D. Roberson	Jefferson City, MO
RN	Geraldine W. Rowe	Clayton, MO
RN	Mary E. Ruggiero	Carthage, MO
RN	Linda S. Schaab	Manchester, MO
RN	Judy M. Schache	Warrensburg, MO
RN	Maureen F. Schaefermeier	St. Johns, MO
RN	Jean M. Schmidt	Richmond, MO
RN	Fay D. Schneider	Fenton, MO
RN	Irma M. Schwieterman	Independence, MO
RN	Judith K. Selzer	Kansas City, MO
RN	Patricia W. Setien	Ballwin, MO
RN	Harriet J. Vann Shepherd	Lees Summit, MO
RN	Vivian K. Sherrill	Farmington, MO
RN	Sharon M. Shoup	Wellsville, MO
RN	Beverly A. Simmerman	Saint Louis, MO
RN	Alsy R. Singleton	Poplar Bluff, MO
RN	Leonita M. Smith	Carthage, MO
RN	Dorothy J. Spencer	Rogersville, MO
RN	Ilona M. Stadnyk	Chesterfield, MO
RN	Beverly S. Steen	Columbia, MO
RN	Margaret A. Stevens	Lee's Summit, MO
RN	Roberta C. Stock	Saint Louis, MO
RN	Doris J. Stoehner	St. Peters, MO
RN	Marsha C. Stonehocker	Independence, MO
RN	Rose L. Suiter	Leadwood, MO
RN	Mary P. Sullivan	Overland Park, KS
RN	Ruth S. Sutton	Malden, MO
RN	Valann Tasch	Chesterfield, MO
RN	Luellyn L. Teel	Gladstone, MO
RN	Betty S. Thomas	Willard, MO
RN	Patricia K. Trachsel	Paola, KS
RN	Carol A. Trost	St. Charles, MO
RN	Louella H. Tunnell	Marshfield, MO
RN	Elaine W. VanderSchaaf-Zgodowska	Chesterfield, MO
RN	Joan C. Velten	Webster Groves, MO
RN	Judith A. Vernier	Millstadt, IL
RN	Patricia A. Volz	Cuba, MO
RN	Michaeline G. Wells	Springfield, MO
RN	Bonnie C. Wesemann	Pleasant Hill, MO
RN	Carol R. Wilbois	Saint Louis, MO
RN	Linda M. Wilcox	Bonne Terre, MO
RN	Caroline S. Windsor	Windsor, MO
RN	Carol M. Witt	Saint Louis, MO
RN	Judith A. Yociss	O' Fallon, IL
RN	Barbara I. Young	Fairfax, MO
RN	Catherine C. Zesch	Saint Louis, MO

Preventing, Detecting, and Investigating Drug Diversion in Health Care Facilities

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Drug diversion harms patients, staff members, the community, institutions, and the diverters themselves. To maintain a safe care environment, institutions must have policies and procedures in place to prevent, detect, and respond to diversion, and the policies and procedures must be followed consistently. This article provides key considerations for developing policies and procedures to prevent and detect drug diversion, to conduct a drug diversion investigation, and to report drug diversion to the appropriate authorities.

Learning Objectives

- Identify risks of drug diversion.
- Discuss how to prevent and detect drug diversion.
- Describe investigative processes related to drug diversion.

The abuse of prescription drugs in the United States is a grave public health concern. The Centers for Disease Control and Prevention (2011) reports a 300% increase in painkiller prescriptions in the United States from 1999 to 2008. Estimates are that 20% of the population age 12 and older has used prescription drugs for nonmedical reasons at least once (National Institute on Drug Abuse, 2011). Health care providers are not immune. Although estimates of substance abuse among various disciplines of health care workers have been made, reliable statistics on the prevalence of drug diversion in health care facilities are not available, at least in part because diversion is by its nature a clandestine activity. However, drug diversion is a "real and constant threat in health care settings" and must be treated as such (State of New Hampshire, 2013). Nurses with a substance use disorder "may turn to the workplace for access or diversion" when they are otherwise unable to obtain the drugs they are using (National Council of State Boards of Nursing, 2014).

Although most health care facilities try to address drug diversion, their approaches vary greatly (McClure, O'Neal, Grauer, Couldry, & King, 2011). Some have formal programs; others manage the problem reactively. Some aggressively monitor and audit activity for drug diversion; others recognize only the most obvious cases. When diversion is detected, some facilities pursue arrest and criminal prosecution, and some do not involve any outside agency. Some facilities treat diverters differently based on their professional role. That is, an institution may have one set of practices for nurses and another for nonclinical staff. For instance, a diverting nurse may be allowed to continue employment and be supported through treatment, while a diverting central supply technician is terminated and reported to law enforcement.

Recent high-profile diversion cases involving substantial patient harm have caused public health and government officials to recognize the threat to patients, health care workers, hospitals, the community, and the diverters themselves. Several initiatives have resulted, and there is momentum behind an effort to mandate that health care facilities develop formal processes to prevent, recognize, and appropriately address drug diversion (Maryland Department of Health and Mental Hygiene, 2013; Minnesota Department of Health/Minnesota Hospital Association, 2013; State of New Hampshire, 2013). This article describes the risks of drug diversion and discusses the use of policies and procedures to prevent, detect, and investigate it.

Risks of Diversion

Several reported cases of diversion-related patient injury demonstrate the magnitude of harm that a diverting health care worker can cause. Typically, patients can be harmed by receiving care from an impaired provider, being denied pain medication, receiving an unsafe substance instead of a controlled substance, or receiving injections from tainted needles, syringes, or vials.

In a 2012 case, a nurse pleaded guilty to theft of hydromorphone in a hospital. The nurse removed hydromorphone from medication bags and replaced it with saline. Twenty-five patients were infected with *Ochrobactrum anthropi*, a blood-borne pathogen. Six required treatment in an intensive care setting; three underwent surgical intervention because of symptoms from an unidentified source; and one died. The nurse was sentenced to 2 years in prison (Hanners, 2013).

In a 2013 case, a radiology technician who had worked extensively as a traveler pleaded guilty in federal court to charges of drug theft and tampering after he was found to have stolen fentanyl at several institutions. He took syringes containing fentanyl, injected himself, replaced the fentanyl with saline, and returned the tainted syringes for patient use. More than 45 patients contracted hepatitis C as a result of his diversion. The technician was sentenced to 39 years in prison (Marchocki, 2013).

A 2012 case illustrates how drug diversion can put the community at risk. An anesthesia assistant was charged with multiple offenses after she was involved in a serious car accident because she was driving the wrong way on a highway. Five people in the other car were injured, some critically. An I.V. bag, a needle, and several vials of propofol were found in the anesthesia assistant's car. It is believed she had just injected herself with propofol she diverted from her workplace and was under the influence at the time of the accident (Ibata, 2012).

When diversion occurs, health care facilities face several areas of risk, including regulatory liability and penalties. Because hospitals are required to provide care in a safe setting free from abuse (42 C.F.R. § 482.13(c), 2006), a diversion case involving patient harm may result in Immediate Jeopardy (Centers for Medicare & Medicaid Services, 2004), which is a threat of termination from the Medicare and Medicaid programs due to deficiencies in care that have or are likely to cause serious injury or death. A diversion event that could result in Immediate Jeopardy, for instance, is a case in which a diverter is substituting saline for an opioid and leaving blood-tainted syringes for use on patients. Health care facilities may also face negative publicity and civil liability as a result of diversion (Miller, 2009; Sanborn, 2013).

Of course, the risks to the diverting health care worker include the loss of his or her professional license. The worker may also be excluded from health care employment by the federal government under the Office of Inspector General's (OIG) exclusionary authority. The OIG, for example, can exclude individuals from work in health care if they are guilty of a felony or misdemeanor drug-related offense. Diverting health care workers also risk incarceration (42 U.S.C. § 1320a-7(a)(4), 1996; 21 U.S.C. § 841 et. seq., 1980), physical injury, and death. They may become infected with a blood-borne pathogen or die of an overdose (Berge, Dillon, Sikkink, Taylor, & Lanier, 2012). Many diverted opiates are in fixed combination with acetaminophen; as the diverter's opiate need escalates, the accompanying dose of acetaminophen can reach lethal levels.

Preventing Diversion

Although diversion cannot be prevented entirely, health care facilities must make every effort to deter it. The first line of defense is comprehensive preemployment screening. The requirements for background checks differ from state to state but, generally, persons who will have access to controlled substances should be assessed for the likelihood that they may be involved in a drug security breach (21 C.F.R. § 1301.90, 1975). References should be carefully checked and should include persons with personal knowledge of the candidate's clinical employment history. Clinical applicants who fail to provide a clinical reference should be regarded with suspicion. During one investigation of a new employee who was diverting, the examiner found that no clinical references had been provided during the hiring process. The new nurse had worked in clinical settings at other institutions over the years, but none of his references were clinical personnel. Eventually, the examiner learned that the nurse had been caught diverting but had been allowed to resign without being reported to the appropriate authorities.

Orientation of new employees should include education about the risks of diversion and the institution's policies regarding diversion. New employees should be made aware of the resources available to them if they find themselves at risk, such as Employee and Professional Assistance programs. Self-reporting protocols should be detailed, if relevant. Any policy of immunity from corrective action, such as allowing individuals who comply with treatment and rehabilitation to keep their jobs, should be fully explained.

Drug Security

The most important feature of a diversion prevention program is drug security. Every facility must ensure that controlled substances and other high-risk drugs are stored securely from the moment they enter the facility until they are used. The Conditions of Participation (COP) for hospitals require that schedules II through V controlled substances be locked in a secure area accessible only to authorized personnel (42 C.F.R. § 482.25(b)(2)(i-iii), 1986). The Joint Commission (2013) also requires safe storage to prevent diversion.

Detailed policies and procedures should ensure the following:

- Storage areas are in locations that can be monitored to prevent unauthorized access.
- Traffic into storage areas is minimized.
- Controlled substance handling, including removal, wasting, and returning, is strictly managed.
- Staff members who administer controlled substances know the requirements that must be met.
- The amount of time drugs are out of secure storage is minimal.
- Unused doses are returned, not wasted.
- Controlled substances are withdrawn for one patient at a time.
- Controlled substances are administered immediately after they are removed from the cabinet.
- Controlled substances are not handed off from one provider to another, or such handoffs are strictly limited.

Many diverting nurses prefer to divert from waste because they believe such diversion does not harm the patient or the institution. One nurse developed a practice of hanging a new bag of hydromorphone for patient-controlled analgesia at the start of every shift, regardless of whether or not the existing bag contained sufficient hydromorphone. She later admitted that this practice allowed her to divert enough hydromorphone waste to meet her ever-increasing needs without having to resort to a more easily identifiable means of diversion.

TABLE 1
Common Behaviors That Raise Suspicions of Diversion

- Frequent tardiness
- Prolonged or frequent bathroom breaks
- Arrival at work when not scheduled
- Early arrival or late departure from work
- Regular requests for overtime or offers to work overtime
- Frequent withdrawal of larger doses than needed
- Wasting of entire doses
- Pattern of removal or wasting near the end of a shift
- Poor judgment
- Inconsistent medical record entries
- Erratic work performance and implausible excuses for poor performance
- Change in personality, appearance, or demeanor
- Drugs or syringes in pockets
- Syringes inappropriately left out
- Patients complaining of unrelieved pain
- Missing medications or discrepancies
- Signs of medication tampering, such as holes in packaging or glue around caps
- Missing prescription pads
- Evidence of tampering with sharps containers

Because wasting a full or partial dose of a controlled substance is an opportunity for diversion, waste should be kept to a minimum. Stock should consist of the smallest practical dosage given the needs of the patients. Facilities should require that all wasting be witnessed by a second authorized person, that wasting be documented, and that both persons sign off on the waste. Any pattern of wasting full doses or maximizing opportunities to waste should be investigated promptly.

Because of the large doses and the accessibility, continuous infusions of controlled substances warrant strict control measures. Frequently, these infusions take place where direct supervision is not feasible. Thus, institutions should use locking cases and portless tubing to reduce the opportunity for diversion. Above all, policies for controlled substance infusions should require frequent documentation of the infusion rate and the amount infused; titration or a bolus dose should be documented when it occurs. Totals should be reconciled at the end of each shift.

Diversion-Risk Rounds

When appropriate prevention policies are in place, facilities should perform diversion-risk rounds regularly

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Preventing continued from page 11

to ensure the continuous safeguarding of controlled substances. Each area where controlled substances are stored and handled should be observed to identify security risks and inappropriate handling. In several diversion cases involving patient harm, handling controlled substances inappropriately and taking shortcuts were identified as the problems (Aston, 2009; State of New Hampshire, 2013). Instances of non-compliance, such as drugs left unattended or unsecured, should be documented, and processes should be refined accordingly.

Detecting Diversion

A program to prevent diversion must operate with the understanding that any person with access to controlled substances may divert them. Frequently, detection of diversion is hampered by preconceived notions of the characteristics of a diverting health care worker. In one case, the diverting nurse was 9 months pregnant, was in graduate school, and had recently received a prestigious award at the facility. Her manager could not be convinced that the nurse might be diverting and using opioids. Even when the nurse admitted to diversion and to being under the influence of drugs she had stolen that day, her manager struggled to believe it.

Some facility personnel erroneously believe a diverter will be unkempt, lazy, and a poor performer. Diverters cannot, however, be recognized by their performance level, personality type, or other obvious features. Diverters may be top performers, new graduates, or senior staff members. Many are well liked by their peers and patients. They are often the "last person" a supervisor would suspect of diverting.

Detection can also be hindered by close relationships between managers and staff members. Many times, a manager knows the staff member's personal situation, and this knowledge clouds the manager's perspective. Managers may overlook behavioral indicators of diversion because they see the diverter only as a bright new graduate, a struggling student, or a team leader. Managers must guard against such misperceptions and be alert to the behavioral indicators of diversion. (See Table 1.) Because of the diverter's desire to maximize opportunities to divert, circumstances associated with a higher risk of diversion include night-shift work, assignment to a critical care area or other unit with increased autonomy, and agency or travel work.

Discrepancies and Suspicious Transactions

Discrepancies in controlled substance counts can be a sign of diversion, yet many facilities experience unresolved discrepancies daily. Discrepancy resolution should be addressed by policy, and discrepancies should never be allowed to remain unresolved for longer than 24 hours. All discrepancies and their resolution should be documented, and the documentation should be reviewed regularly to ensure that a concerning pattern does not go unrecognized.

Many facilities have automated drug cabinets that produce dispensing reports that flag suspicious transactions. This technology is less common in long-term care facilities. However, even when a facility uses analytical software to flag suspicious transactions or trends, drug cabinet records must be compared with medication administration records and nurses' notes. Many transactions that were highly suspicious for diversion have been explained when entries in the medical record were reviewed. Procedures specific to a particular area can provide a justification for actions that otherwise seem to be a cause for concern.

Each facility should have an auditing plan that involves a review of controlled substance transactions on a regular basis. Regular review enables facilities to identify worrisome transactions and address them quickly, minimizing the risk of patient harm. For the auditing program to be effective, those involved must be familiar with common methods of diversion. (See Table 2.)

Staff Education

Education of all staff members is even more important for detection than it is for prevention. Each staff member, including ancillary staff members, should be apprised of common signs of diversion and impairment. In some cases, housekeepers, dietary aides, and maintenance workers have reported concerns or observations that were found to be associated with diversion. In one case, a unit secretary found an empty fentanyl bag in the staff bathroom trash can. A review of fentanyl transactions revealed that a nurse had removed three fentanyl bags that day for patients who did not have orders for fentanyl.

Staff members should be advised of reporting avenues and an option to remain anonymous, and they should be informed of their obligation to report. The Controlled Substance Act states that reports of diversion are an essential part of the facility's program, and they serve the public at large (21 C.F.R. § 1301.91, 1975). The Act goes on to say, "An employee who has knowledge of drug diversion from his employer by a fellow employee has an obligation to report such information to a responsible security official of the employer" (21 C.F.R. § 1301.91, 1975).

Facility Investigation of Diversion

A suspicion of diversion warrants an immediate, thorough investigation. An audit that reveals a statistical outlier in the dispensing or wasting of controlled substances requires further investigation. Reports of telltale behaviors or behavioral changes should raise concerns about diversion.

When a substantial probability of diversion is found, a core team of knowledgeable persons in the facility should meet to determine whether to confront the suspected diverter or monitor the situation. Having one person make this decision places too much responsibility on that person. A shared decision is much more likely to be insightful and objective.

To confirm diversion, investigators should include a review of the dispensing patterns of the nurse: Is there a drug that the nurse uses more frequently than his or her peers? Is there a pattern of escalating use of a particular controlled substance? Investigations should also include a discussion with the supervisor of the suspected diverter.

If an interview with the suspected diverter is appropriate, he or she should be removed from patient contact, and access to controlled substances should be terminated pending the conclusion of the investigation. These steps address patient safety concerns and help avoid the possibility of further diversion.

TABLE 2
Common Methods of Diversion

- Removal of medication when the patient does not need it
- Removal of medication for a discharged patient
- Removal of a duplicate dose
- Removal of fentanyl patches
- Removal of medication without an order
- Removal under a colleague's sign-on
- Substitution of a noncontrolled substance for a controlled substance
- Theft of patient medications brought from home
- Failure to waste when indicated
- Frequent wasting of entire doses

Interview and Testing

The interview should occur at a location that ensures privacy. The meeting with the suspected diverter should be with a small group and should include a person whom the suspected diverter regards as supportive. This group often consists of the supervisor of the employee, the individual who detected suspicious activity through surveillance, and a human resources representative.

The tone of the interview should be professional, but evidence suggesting diversion should be made clear. The suspected diverter should be given an opportunity to explain, and the nature of the meeting should encourage a confession, if appropriate.

Nearly all reasonable-suspicion interviews lead to a drug screen. The facility should be familiar with drug testing panels and ensure that any drug that is the subject of the investigation is part of the panel obtained. There have been publicized cases of diversion in which the diverting health care worker underwent a drug screen, but the result was negative because the investigators did not know that the panel could not detect the suspected drug; most standard urine drug screen panels, for example, do not test for the presence of fentanyl. Each facility should have a procedure for evaluating the results of the drug screen, including consultation with a qualified medical review officer.

Though not mandated, a procedure should be in place to test the diverter for blood-borne pathogens if the contamination of drug vials, fluids, or equipment is possible. The procedure should include discussing the reasons for requesting the test and asking the employee for consent to undertake it. The employee must be advised that a decision not to provide blood carries no penalty; consent is voluntary. Also, the employee may select the blood-borne pathogens for which he or she will be tested (HIV, hepatitis B virus, or hepatitis C virus). The testing process is handled in the same fashion as an occupational exposure test, so the results are confidential and are disclosed to appropriate authorities only if the employee tests positive. Early identification of the risk of transmission of a blood-borne pathogen can facilitate appropriate testing and treatment for patients who may have been exposed.

Reporting Drug Diversion

Facilities may have difficulty detecting diversion, and when they do, they are reluctant to report it externally. Some, citing compassion or loyalty, may allow the diverter to resign without further action. They fear negative publicity and are often concerned about state and federal

Preventing continued on page 13

Preventing continued from page 12

agency involvement. Others are unsure of requirements and avenues for reporting in their jurisdiction. However, when diversion is confirmed, mandatory reporting must occur without delay, including reporting to the Drug Enforcement Administration (21 C.F.R. § 1301.76(b), 1971) and the state licensure board and professional assistance program.

Nurse practice acts in all states require nurses to report unprofessional, illegal, and unsafe practice to the appropriate board (Tennessee Board of Nursing, 2007). Patient-harm issues usually require reporting to the state Department of Health within a narrowly prescribed time. In some states, the state pharmacy board may require notification, and there may be mandatory reporting to local police. Diversion is a criminal act and must be treated as such (State of New Hampshire, 2013). Facilities should also be aware of alternative programs and professional assistance programs available in their jurisdiction and should refer diverting employees to these programs for evaluation, treatment, and monitoring, as appropriate.

Facilities are encouraged to determine their reporting requirements and to reach out to the relevant agencies to ensure they have the requisite contact information before they have a diversion case. A discussion between the facility and the authorities helps establish the expectations of each side and can bolster a cooperative working relationship. Regardless of the reason, facilities that don't report diversion are complicit in the individual's subsequent diversion activities at other institutions.

Drug diversion is an emotionally charged issue, and having policies and procedures can help ensure that cases are handled consistently. The disposition of cases should not depend on the employee's job title, seniority, or the preference of the employee's supervisor. It is imperative that the investigation and reviews be consistent; accusations of bias can easily occur when the investigative method is erratic or inconsistent (O'Neal & Siegel, 2007).

Regulatory Investigation

A regulatory investigation into health care facility diversion is aimed in part at identifying process deficiencies and thus should include an evaluation of the essential components of the diversion program. Regulatory investigations typically result from institutional self-reporting and from patient complaints. The investigation may be conducted by a BON investigator or other investigators from a State Department of Health-Related Board. As with any investigation, verification of institutional processes can be accomplished by observing the practices, interviewing the staff members, and reviewing the policies, procedures, and other relevant documents. Though policies and procedures are valuable, controlled substance security requirements frequently are not followed uniformly across an organization.

A review of drug security is necessary. Policies and procedures should address the tracking of controlled substances from receipt to disposition, and documentation of such tracking should be provided by the facility for review. Gaps in security can occur in the location where drugs are delivered by the shipper, in the pharmacy, in transport within the facility, and in the clinical areas. Unauthorized access must be prevented by physical security measures and strict limitations at all steps in the handling process.

Particular attention should be paid to procedural areas. Because of the nature of the care in these areas, enforcing controlled substance security can be challenging. The patient population is also inherently vulnerable to harm from diversion. If controlled substances must be removed from a drug cabinet before a surgical procedure, they should be secured pending use. Acceptable methods of securing these medications include the use of cabinet-mounted lockboxes or locked drawers. All pre-drawn syringes should be labeled and initialed. Access to lockbox or drawer keys should be restricted to individuals authorized to administer controlled substances.

Policies and Procedures

Facilities should be able to produce policies and procedures reflecting the way they audit dispensing practices and investigate anomalous findings. Policies should identify who has responsibility for daily monitoring. Those involved in monitoring should know the requirements for handling controlled substances and the activity that should be considered suspicious for drug diversion. The criteria for proceeding with an investigation need not be spelled out because many factors contribute to that decision, but the person or persons responsible for the investigation within the facility should be identified.

Institutional policies and procedures must say explicitly which steps will be taken when diversion is confirmed, and this process should be followed in all cases. Internal reporting to executive leadership or a review committee should occur when indicated and should be documented. Policies should address which external agencies will be notified and who is responsible for reporting. Reporting to external agencies should be verified. The COP for hospitals state that abuses and losses of controlled substances must be reported in accordance with federal and state laws to the individual responsible for the pharmaceutical service and the chief executive officer, as appropriate (42 C.F.R. § 482.25(b)(7), 1986).

The possibility of patient harm must be addressed in every diversion case. This should be undertaken by the facility, but should also be verified by regulatory investigators. A determination should be made whether any patient was denied adequate analgesia, given an unauthorized substitute, provided substandard care by an impaired provider, or otherwise harmed.

All instances of diversion should be followed by root cause analysis and process improvement to reduce the risk of future events. Conditions that contributed to the diversion should be identified and eliminated to the extent possible. The COP for hospitals state, "If tampering or diversion occurs, or if medication security otherwise becomes a problem, the hospital must evaluate its current medication control policies and procedures, and implement the necessary systems and processes to ensure that the problem is corrected, and that patient health and safety are maintained" (42 C.F.R. § 482.25(b)(2)(i-ii), 1986). These reviews help identify opportunities for improvement, monitor trends in the institution, and perpetuate diversion awareness in the organization.

Conclusion

Diversion is a criminal activity that harms patients, institutions, staff members, the community, and the diverters themselves. Institutions have a duty to provide a safe care environment in which the risk of diversion is kept to a minimum. Thus, institutions must have policies and procedures in place to prevent, detect, and respond to diversion, and the policies and procedures must be followed consistently and without prejudice.

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Preventing, Detecting, and Investigating Drug Diversion in Health Care Facilities

Learning Objectives
- Identify risks of drug diversion.
- Discuss how to prevent and detect drug diversion.
- Describe investigative processes related to drug diversion.

ce

CE Posttest

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Posttest

Please circle the correct answer.

1. **When a nurse is found guilty of a felony drug-related case, what action can the Office of Inspector General (OIG) take?**
   a. Revoke a nurse's license
   b. Exclude the person from future work in health care
   c. Require participation in an alternative-to-discipline program
   d. Offer job placement advice

2. **What is the risk of diversion for patients?**
   a. Incarceration
   b. Overdose
   c. Infection
   d. Notoriety

3. **What is the most important reason to detect and intervene when a nurse is suspected of diversion?**
   a. To teach a lesson to other staff members
   b. To protect the health care facility from legal action
   c. To prevent bad publicity
   d. To protect the safety of patients

4. **What is "Immediate Jeopardy?"**
   a. The potential for a health care facility to be terminated from the Medicare and Medicaid programs
   b. A loss of accreditation by the Joint Commission
   c. A department of health deficiency following a health care agency survey
   d. The penalty for not reporting diversion to local law enforcement

5. **What should raise a red flag about a nurse during preemployment screening?**
   a. Working part time at several different facilities
   b. Lack of clinical references
   c. Willingness to work any shift
   d. Wearing long sleeves

6. **What is the most important feature of a diversion prevention program?**
   a. Drug security
   b. Education of newly hired nurses
   c. Immunity-free policy
   d. Zero tolerance policy

7. **Which behavior should raise suspicions of diversion?**
   a. Calling in sick
   b. Pattern of wasting of entire doses
   c. Switching work schedule to day shift
   d. Meeting colleagues after work for a cocktail

8. **What is the most common characteristic of a nurse who diverts a drug?**
   a. New graduate
   b. Well liked by colleagues
   c. Unkempt and lazy
   d. No common characteristic

9. **What should happen if there is a discrepancy in controlled substance counts?**
   a. The discrepancy must be resolved without 24 hours.
   b. The police must be contacted.
   c. Staff members are not allowed to leave the floor.
   d. All nurses must submit to urine drug tests.

10. **What is a requirement of the Conditions of Participation?**
    a. Drug counts must be accurate.
    b. Controlled substances must be locked in a secure area.
    c. Wasted drugs are returned to the pharmacy.
    d. Unused doses are wasted, not returned.

11. **What is the purpose of an audit?**
    a. To reveal a statistical outlier in the dispensing or wasting of controlled substances
    b. To highlight the need for better drug security
    c. To identify nurses most at risk for diversion
    d. To observe high-risk areas

12. **A nurse is suspected of diversion. What should happen next?**
    a. Investigation
    b. Interview
    c. Termination
    d. Drug testing

13. **A nurse admits to diverting fentanyl and submits to a standard urine drug screen. Why would the drug screen come back negative?**
    a. The nurse is lying about diverting drugs.
    b. The drug screen panel does not test for the drug.
    c. The urine sample was compromised.
    d. The urine sample was not tested properly.

14. **A nurse's behavior causes harm to a patient. What action is now required by the nurse practice act?**
    a. Allow the nurse to resign.
    b. Refer the nurse to a substance abuse program.
    c. Report the nurse to the board of nursing.
    d. Fire the nurse.

15. **What federal law states that reporting diversion "serves the public at large?"**
    a. Drug Enforcement Act
    b. Omnibus Budget Reconciliation Act
    c. Controlled Substances Act
    d. Social Security Act

Evaluation Form (required)

1. **Rate your achievement of each objective from 5 (high/excellent) to 1 (low/poor).**
- Were the methods of presentation (text, tables, figures, etc.) effective?
  1 2 3 4 5
- Was the content relevant to the objectives?
  1 2 3 4 5
- Identify risks of drug diversion.
  1 2 3 4 5
- Discuss how to prevent and detect drug diversion.
  1 2 3 4 5
- Describe investigative processes related to drug diversion.
  1 2 3 4 5

2. **Rate each of the following items from 5 (very effective) to 1 (ineffective):**
- Was the author knowledgeable about the subject?
  1 2 3 4 5
- Was the article useful to you in your work?
  1 2 3 4 5
- Was there enough time allotted for this activity?
  1 2 3 4 5

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Pursuant to Section 335.066.2 RSMo, the Board "may cause a complaint to be filed with the Administrative Hearing Commission as provided by chapter 621, RSMo, against any holder of any certificate of registration or authority, permit, or license required by sections 335.011 to 335.096 or any person who has failed to renew or has surrendered his certificate of registration or authority, permit or license" for violation of Chapter 335, the Nursing Practice Act.

**Please be advised that more than one licensee may have the same name. Therefore, in order to verify a licensee's identity, please check the license number. Every discipline case is different. Each case is considered separately by the Board. Every case contains factors, too numerous to list here, that can positively or negatively affect the outcome of the case. The brief facts listed here are for information only. The results in any one case should not be viewed as Board policy and do not bind the Board in future cases.

CENSURE

Landers, Deberah G.
Saint Louis, MO
Licensed Practical Nurse 029373
Licensee's license expired on May 31, 2012 and lapsed on June 1, 2012. Licensee practiced nursing in Missouri without a license from June 1, 2012 to May 15, 2014.
Censure 07/03/2014 to 07/04/2014

Bono, James M.
Saint James, MO
Registered Nurse 153825
On three separate occasions in July 2010, while on duty for a weekend shift in the intensive care unit, Respondent fell asleep in an empty patient bed. There were four patients with two nurses during these shifts.
Censure 07/22/2014 to 07/23/2014

Clay, Jaunice S.
Saint Louis, MO
Licensed Practical Nurse 053062
Throughout Respondent's probation, Respondent has failed to call NTS on thirteen (13) different days. Further, on May 8, 2013, and January 22, 2014, Respondent called NTS and was advised that she had been selected to provide a urine sample for screening. Respondent failed to report to a collection site to provide the requested samples.
Censure 07/09/2014 to 07/10/2014

Timberlake, Johna Ann
Kansas City, MO
Licensed Practical Nurse 2000168587
Licensee worked from June 1, 2012 through May 21, 2014, on a lapsed license.
Censure 07/31/2014 to 08/01/2014

Chapman, Carolyn Blair
Fenton, MO
Registered Nurse 2000147912
On August 7, 2013, Corrections Officer MW brought inmate ML to Licensee for treatment. Inmate ML complained of having athlete's foot. Licensee documented that she inspected the appearance of inmate ML's feet and checked "yes" to indicate that cracking and peeling were present. Corrections Officer MW reported that Licensee did not have inmate ML remove his shoes or socks and did not visually inspect inmate ML's feet. Licensee admitted that she did not visually inspect inmate ML's feet. Licensee falsely documented in inmate ML's medical chart. On June 14, 2013, Licensee failed to contact the physician when an inmate complained of chest pains.
Censure 07/10/2014 to 07/11/2014

Johnson, Mary Ann
East Saint Louis, IL
Registered Nurse 2010010980
Resident MM resided at a care center since December 31, 2009. When resident MM first arrived at the facility, she slipped while being given a bath and has been afraid to take baths ever since that incident. Care Center staff had been giving her bed baths twice a week since that incident. On September 8, 2011, Licensee and another nurse, CB, informed resident MM that she was going to take a bath. Resident MM told them she would not take a bath and explained that she received bed baths. Licensee and nurse CB proceeded to lift resident MM from her bed and transfer her to a wheelchair. Resident MM grabbed the side rails of her bed and tried to keep herself from being moved. Licensee and nurse CB removed resident MM's hands from the side rails and took her to the shower room. Licensee and nurse CB forced resident MM to take a bath against her wishes. As she was being bathed, resident MM continued to say she did not want a bath and was crying and screaming during the bath.
Censure 08/15/2014 to 08/16/2014

Uptegrove, Jacinda Renee
Clinton, MO
Registered Nurse 2000146059
The Board did not receive a thorough chemical dependency evaluation submitted on Respondent's behalf by the November 1, 2013, documentation due date. The Board did not receive proof

CENSURE continued...

of completed continuing education hours covering the required courses by the March 20, 2014, documentation due date.
Censure 07/16/2014 to 07/17/2014

Dillard, Sarah E.
Springfield, MO
Registered Nurse 120117
Throughout Respondent's probation with the Board, Respondent failed to call in to NTS on eight (8) different days. Respondent failed to call NTS on April 29, 2014, which was a day she was selected to be tested; therefore, Respondent failed to submit to a required drug and alcohol test on April 29, 2014. In addition, on April 18, 2014, Respondent reported to a lab and submitted the required sample which showed a low creatinine reading of 15.8.
Censure 07/09/2014 to 07/10/2014

Thomas, Dwighteasha Denise
Alton, IL
Registered Nurse 2010028207
Respondent was late in completing the contract process with NTS. Respondent failed to call in to NTS on seven (7) days. Further, on September 6, 2013; December 20, 2013; and January 8, 2014, Respondent called NTS and was advised that she had been selected to provide a urine sample for screening. However, Respondent failed to report to a collection site to provide the requested sample. The Board did not receive a thorough chemical dependency evaluation submitted on Respondent's behalf by the due date of September 3, 2013; however, the Board did receive a chemical dependency evaluation submitted on Respondent's behalf on September 17, 2013.
Censure 07/07/2014 to 07/08/2014

Landman, Roxanne
Saint Louis, MO
Registered Nurse 142595
Respondent holds a Certificate of Registration as a Registered Nurse, issued by the Department of Financial and Professional Regulation of the State of Illinois (Department). Respondent signed a Consent Order with the Department of Financial and Professional Regulation of the State of Illinois on June 14, 2010, which was approved and went into effect on June 29, 2010. Respondent's Illinois Registered Nurse license was placed on indefinite probation for a minimum period of three years. Respondent renewed her Missouri registered professional nursing license in 2011 and answered "No" when asked "Have you ever had any professional license, certification, registration, or permit revoked, suspended, placed on probation, or otherwise subject to any type of disciplinary action?" This was after Respondent had her Illinois Registered Nursing license placed on discipline. On April 28, 2014, a Consent Order was issued by the Department of Financial and Professional Regulation, Division of Professional Regulation stating that Respondent complied with the terms of the Illinois Order dated August 3, 2010, and that her Illinois nursing license was removed from probationary status and reinstated to active unencumbered status.
Censure 07/07/2014 to 07/08/2014

Willis, Lenore M.
Saint Ann, MO
Licensed Practical Nurse 053867
Licensee's license expired on May 30, 2012. Licensee practiced nursing in Missouri without a license from June 1, 2012 to April 23, 2014.
Censure 07/15/2014 to 07/16/2014

PROBATION

Frydman, Bettie C.
Saint Joseph, MO
Licensed Practical Nurse 028505
On August 17, 2011, the family of resident D.B. reported their concerns to the facility about the care that he received at the facility. The family reported that on August 17, 2011, D.B. was shaky and could not feed himself all day. They stated that he was too weak for therapy and to go to the dining room. The facility's investigation into D.B.'s care, as described below, revealed that he felt ill in the dining room at breakfast, was unable to eat and had dry heaving and vomiting shortly after breakfast. During the day, D.B. was shaky and weak with an erratic pulse. At 18:30 on August 17, D.B.'s aunt called and talked to D.B. He was so weak that he dropped the phone which was a large departure in his health from earlier in the day and the previous day. The aunt called Licensee and asked that she check on D.B. Licensee stated she would check on D.B., put the phone down and returned to the phone stating he just needed to use the urinal. D.B.'s daughter also called the patient's son who came in at 19:00 and found D.B. clammy, chest rattling, sweating, and his speech was difficult and he was having trouble breathing. The night nurse checked a pulse oximeter and found the result to be 82%. The family said the night nurse responded to D.B.'s condition and got D.B. transferred to the emergency room. D.B.'s family felt that Licensee ignored the patient's condition throughout the day which resulted in his deteriorated condition and trip to the emergency room. The facility terminated Licensee on August 22, 2011 for lack of sound professional judgment. The facility determined that Licensee failed to do an assessment of D.B. after

PROBATION continued...

his family reported his deteriorating condition. Licensee's failure to properly assess her patient is below the standard of care for a nurse.
Probation 06/26/2014 to 06/26/2017

Cox, Leanna Dawn
Sedalia, MO
Licensed Practical Nurse 2012027144
On April 2, 2013, Licensee signed for the delivery of thirty Xanax tablets for ML. At that time, there was a care center policy in place that required that narcotics received from the pharmacy had to be placed in the locked narcotic box inside the medication room. Licensee placed the Xanax in the Med Room, but did not place them in the narcotic box. Licensee later admitted to the Board's investigator that she signed for a medication delivery and did not follow the care center policy for handling the receipt of controlled substances. On April 3, 2013, it was reported to the Director of Nursing that the patient ML was almost out of Xanax and the delivery which was received the previous day was now missing. All care center nursing staff who had access to the medication room between April 2, 2013 and April 3, 2013 were requested to submit a sample for drug testing. Licensee provided a sample for testing on April 4, 2013. The sample that Licensee submitted for testing tested positive for alpha-hydroxyalprazolam, Lorazepam, Oxazepam, and Temazepam. Licensee provided evidence that she has a prescription for Lorazepam. Licensee did not provide a prescription for alpha-hydroxyalprazolam, alprazolam, Oxazepam, and Temazepam.
Probation 06/17/2014 to 06/17/2016

Chaney, Michelle Lynn
Kansas City, MO
Registered Nurse 2014028376
On April 3, 1996, Applicant pled guilty to driving while intoxicated. On or about July 11, 2011, Applicant pled guilty to driving while intoxicated. On or about January 10, 2012, Applicant pled guilty to driving while intoxicated.
Probation 08/05/2014 to 08/05/2019

Reinhardt, Amanda Jean
O Fallon, IL
Registered Nurse 2008023805
A pharmacy audit revealed discrepancies in Licensee's dispensing and documenting of Dilaudid. On September 29, 2011, pharmacy records show Licensee removed Dilaudid from the Pyxis system for patient G.T. at 18:26. Licensee did not document the administration or waste of the Dilauded.
Probation 06/25/2014 to 06/25/2017

Florez, Ashley Lee
Raytown, MO
Registered Nurse 2008020018
Licensee sent in an explanatory letter to the Board on May 30, 2013 in which she explained that she pled guilty in the state of South Dakota to a DUI and also to possession of a controlled substance. Licensee entered pleas of guilty to possession of a controlled substance (Hydrocodone) and also to driving while intoxicated. The record states that these pleas were entered by Licensee on November 21, 2012. On a routine review of Licensee's driving record, Board staff discovered that Licensee had another conviction in the state of South Dakota. Licensee's other conviction was from an arrest for DWI that occurred on January 12, 2013 and for which she pled guilty to DWI on March 19, 2013 and was found guilty by the court on March 27, 2013.
Probation 06/05/2014 to 06/05/2019

Cragen, Deborah Jo
Indianapolis, IN
Registered Nurse 2002030317
This Board and Respondent entered into a Settlement Agreement which became effective on August 6, 2013. Pursuant to the terms of Respondent's probation in the Agreement, Respondent was required to provide of copy of the Agreement to any current employer as soon as she receives it and no later than during her next work shift or her employer's next working day and to any potential employer prior to acceptance of any offer of employment. Respondent did not provide her employer a copy of the Agreement within those time frames. Respondent was required to meet with representatives of the Board at such times and places as required by the Board. Respondent did not attend the meeting or contact the Board to reschedule the meeting. In accordance with the terms of the Agreement, Respondent was required to submit to the Board quarterly, either employer evaluations or statements of unemployment. Respondent did not submit an employer evaluation or statement of unemployment by the quarterly due date of May 6, 2014.
Probation 07/09/2014 to 07/09/2015

White, April Nicole
Camdenton, MO
Licensed Practical Nurse 2010007940
On December 9, 2013, Licensee pled guilty to the class C felony of possession of a controlled substance in the Circuit Court of Camden County, Missouri. She last used methamphetamines on June 21, 2013 and last consumed alcohol on December 1, 2012.
Probation 07/16/2014 to 07/16/2019

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Probation continued from page 15

Dutra, Lori Ann
Monett, MO
Registered Nurse 2012010235
On June 22, 2013, licensee removed Protonix from a Pyxis machine and administered it to a patient but did not document in the medical record that the medication was actually administered to a patient. Another nurse nearly administered the same medication to the patient but discovered the error when the patient confirmed he had had the medication. On June 22, 2013, licensee failed to follow protocol when licensee became aware that one of her patients had potassium levels that were outside of the normal ranges. Although there were standing orders to treat the patient for this condition, licensee failed to obtain the standing orders and treat the patient for this condition in accordance with policies. On June 26, 2013, licensee documented in a patient's record that only 300 ml of voided fluid was in a bedside commode when in actuality 2000 ml of voided fluid was in the commode. On June 26, 2013, licensee was instructed by a charge nurse to complete patient rounds as required as part of her duties and licensee failed to complete those rounds. In a counseling session conducted with officials on July 12, 2013, licensee was asked in regard to her documentation of "pain scores" on several different patients, why so many of them were "zero." Licensee admitted that she did not wake patients up to ask them about their pain and just "put in the number." The tracking system showed that licensee was not even in the patients' rooms when these types of entries for various patients' pain scores were made.
Probation 07/15/2014 to 07/15/2016

Triplett, Deborah Sue
Springfield, MO
Registered Nurse 143454
On August 1, 2013, Licensee was observed by another nurse to remove a Zofran tablet from the medication cart and ingest it.
Probation 07/17/2014 to 07/17/2016

Smith, Evelyn D.
Saint Louis, MO
Licensed Practical Nurse 039184
On September 30, 2005, Respondent was given a Verbal Counseling for failing to transcribe physician's orders. On April 19, 2006, Respondent was given a Verbal Counseling for failing to fill out a medication sheet. On June 13, 2007, Respondent was given a Written Counseling for failing to transcribe three (3) sets of physician orders on a consumer. As a result of this failure, the consumer missed medications and had an escalation in behavior and a code yellow was called. On September 12, 2007, Respondent was given a Verbal Reminder for two (2) medication errors that occurred on two (2) different dates. On September 25, 2008, Respondent was given a Verbal Reminder for failing to document a medication was given on two (2) specific dates. On January 26, 2009, Respondent was given a Written Counseling for failing to document medication that was given to three (3) consumers. On May 29, 2010, Respondent was given a Written Reprimand. Respondent failed to do the narcotic count with the oncoming nurse, and took the narcotic keys home and was unable to return the keys until the following day. On June 24, 2010, Respondent was given a written reprimand when a syringe was found by a patient's bedside. Respondent was the only nurse to give the patient an injection on that shift that day. On July 1, 2010, Respondent received an education review session with the Nurse Educator due to medication errors. On September 22, 2010, and October 27, 2010, Respondent failed to transcribe lab orders. This error resulted in the labs not being done. On

PROBATION continued...

December 13, 2010, Respondent was given a Written Counseling for improper order transcription regarding a laboratory test. On April 12, 2011, Respondent documented that she administered patient PM Ativan. The Ativan was found unopened in the patient's medication drawer. On June 28, 2011, Respondent was given a Written Counseling for improper medication administration. In July 2011, Respondent received an education review session with the Nurse Educator due to medication errors. On September 20, 2011, Respondent was placed on a ninety-day "Conditional Employment" period for making continued medication errors. On December 18, 2011, Respondent documented that she gave patient MH two (2) doses of Bupropion. The two doses of Bupropion in question were found unopened in the patient's medication drawer. On December 23, 2011, Respondent misplaced the medication room keys. On January 20, 2012, Respondent was placed on a sixty-day period of Conditional Employment for making continued medication errors. Respondent was warned that any future errors would result in dismissal from employment. On February 2, 2012, Respondent documented that she administered 0900 medications to patient BB. The medications included Dilantin, Theracran, Thiamin and Vitamin D. The medications were found unopened in the patient's medication drawer.
Probation 07/10/2014 to 07/10/2019

Riddle, Kathryn R.
Pleasant Valley, MO
Registered Nurse 127891
On December 1 and 2, 2012, Licensee withdrew acetaminophen-hydrocodone 325/5. Licensee did not document the administration or waste of the acetaminophen-hydrocodone. On December 7, 2012, Licensee withdrew two tablets of acetaminophen-hydrocodone 325/5 at 14:27. Licensee documented the tablets as administered at 14:00, which is impossible as that is before Licensee withdrew the medication. On December 7, 2012, Licensee withdrew one 100 mcg fentanyl patch. Licensee charted that she did not administer the fentanyl patch, but did not document the return or waste of the fentanyl patch. From December 7, 2012 through December 11, 2012, patient had an order for three 5 mg tablets of oxycodone to be administered at 09:00, 13:00, 17:00, and 21:00. On December 10, 2012, Licensee withdrew three 5 mg tablets of oxycodone at 13:12. On December 10, 2012, Licensee withdrew three 5 mg tablets of oxycodone at 15:34. On December 10, 2012, Licensee withdrew three 5 mg tablets of oxycodone for patient at 15:58. On December 10, 2012, Licensee withdrew three 5 mg tablets of oxycodone for patient at 17:37. Licensee documented the doses of oxycodone as administered at 13:00, 13:13, and 17:00. Licensee failed to document the administration or waste of three 5 mg tablets of oxycodone, and inappropriately charted the administration of oxycodone at 13:13 when patient was not scheduled to receive the oxycodone. On December 13 and 19, 2012, Licensee withdrew morphine. Licensee did not document the administration or waste of the morphine. On December 19, 2012, Licensee withdrew one vial of lorazepam 2mg/1ml at 17:53. Licensee documented the waste of 1.5 mg of the lorazepam at 17:57, but did not document the administration or waste of the remaining 0.5 mg of lorazepam. On December 29, 2012, Licensee withdrew two tablets of acetaminophen-hydrocodone 325/5 at 16:44. Licensee documented the tablets as administered at 16:05, which is impossible as that is before Licensee withdrew the medication. On December 30, 2012, Licensee withdrew two tablets of acetaminophen-hydrocodone 325/5 at 13:33. Licensee documented the tablets as administered at 13:00, which is impossible as that is before Licensee withdrew the medication. On January 7, 2013, Licensee withdrew one

PROBATION continued...

tablet of acetaminophen-hydrocodone 325/5 at 17:47. Licensee documented the tablet as administered at 17:00, which is impossible as that is before Licensee withdrew the medication. On January 8, 2013, Licensee withdrew one tablet of clonazepam 0.5 mg at 16:08. Licensee documented the tablet as administered at 15:00, which is impossible as that is before Licensee withdrew the medication. On January 9, 2013, patient was scheduled to receive one tablet of clonazepam 0.5 mg at 09:00 and 15:00. Licensee withdrew one (1) tablet of clonazepam 0.5 mg for patient at 13:09 and 17:38. Licensee charted the administration of one tablet of clonazepam 0.5 mg at 09:00, which is impossible as that is before Licensee withdrew the medication. Licensee failed to document the administration or waste of remaining 0.5 mg of clonazepam. On January 9, 2013, Licensee withdrew three 5 mg tablets of oxycodone at 13:09. Licensee failed to document the administration or waste of the oxycodone. On January 9, 2013, Licensee withdrew one vial of lorazepam 2mg/1ml at 11:53. Licensee documented the administration of 1 mg of the lorazepam at 12:55, an hour after she withdrew the medication, and Licensee failed to document the waste of the remaining 1 mg of lorazepam. On January 9, 2013, Licensee withdrew one vial of morphine 4mg/1ml at 17:29. Licensee did not document the administration or waste of the morphine. On January 11, 2013, Licensee withdrew one vial of lorazepam 2mg/1ml at 13:03. Licensee did not document the administration or waste of the lorazepam. On January 11, 2013, Licensee withdrew one vial of morphine 2mg/1ml at 13:03. Licensee did not document the administration or waste of the morphine. On January 12, 2013, Licensee withdrew one vial of morphine 4mg/1ml at 15:57. Licensee documented the morphine as administered at 14:30, which is impossible as that is before Licensee withdrew the medication. On January 13, 2013, Licensee withdrew one 100 mcg fentanyl patch at 13:32. Licensee documented the fentanyl patch as administered at 11:00, which is impossible as that is before Licensee withdrew the medication. On January 13, 2013, Licensee withdrew one vial of morphine 4mg/1ml at 16:22. Licensee did not document the administration or waste of the morphine. On January 14, 2013, Licensee withdrew one vial of morphine 4mg/1ml at 10:56 and two vials of morphine 4mg/1ml at 13:13. Licensee did not document the administration or waste of the three vials of morphine. On January 14, 2013, Licensee withdrew one vial of lorazepam 2mg/1ml at 13:59. Licensee documented the administration of 1.0 mg of the lorazepam at 14:00, but did not document the administration or waste of the remaining 1.0 mg of lorazepam. On January 16, 2013, Licensee withdrew two tablets of acetaminophen-hydrocodone 325/5 at 13:46. Licensee did not document the administration or waste of the acetaminophen-hydrocodone. On January 16, 2013, Licensee withdrew one tablet of alprazolam 0.5 mg at 13:54. Licensee did not document the administration or waste of the alprazolam. On January 24, 2013, Licensee withdrew one vial of hydromorphone 2mg/1ml at 1523. Licensee documented the administration of 1.0 mg of the hydromorphone at 16:30, but did not document the administration or waste of the remaining 1.0 mg of hydromorphone. On January 25, 2013, Licensee withdrew one vial of hydromorphone 2mg/1ml at 17:36. Licensee documented the waste of 1.0 mg of the hydromorphone at 17:44, but did not document the administration or waste of the remaining 1.0 mg of hydromorphone. On January 28, 2013, Licensee withdrew four oxymorphone 10 mg tablets at 10:25. Licensee documented the tablets as administered at 07:30, which is impossible as that is before Licensee withdrew the medication. On January

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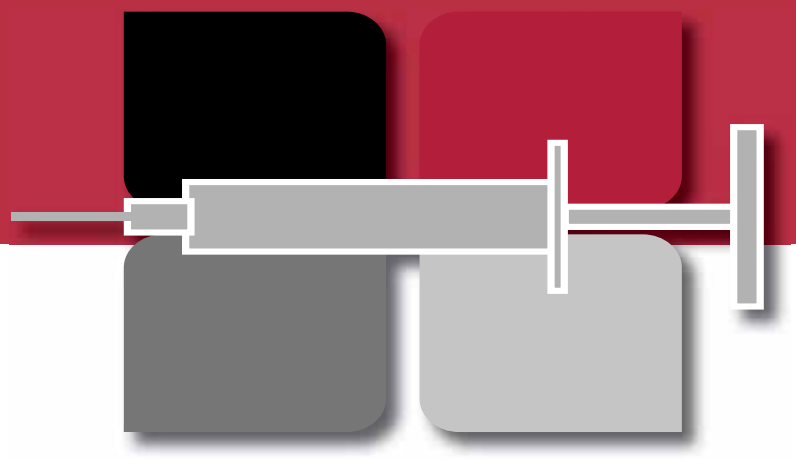
ShowMeVax

Missouri's Immunization Registry



Did You Know?

ShowMeVax is Missouri's free immunization registry that:

- is accessible through the web or EMR/EHR systems;
- helps eligible providers with EMR/EHR systems receive incentive payments;
- ensures patients are properly immunized;
- provides secure access for health care providers to patient immunization records (currently 35 million) throughout the state;
- reduces staff time spent obtaining immunization records; and
- simplifies vaccine ordering for the Vaccines for Children program providers.

For more information visit health.mo.gov/showmevax or contact the Bureau of Immunization Assessment and Assurance at 877.813.0933 or showmevaxsupport@health.mo.gov

Probation continued from page 16

28, 2013, Licensee withdrew four oxymorphone 10 mg tablets at 18:33. Licensee documented the tablets as administered at 18:00, which is impossible as that is before Licensee withdrew the medication. On January 28, 2013, Licensee withdrew two tablets of acetaminophen-hydrocodone 325/5 at 17:28. Licensee did not document the administration or waste of the acetaminophen-hydrocodone. Licensee failed to accurately chart the administration and waste of controlled substances. Licensee demonstrated inconsistent practice related to medication administration and waste.
Probation 06/24/2014 to 06/24/2017

Runion, Amy Marie
Mount Vernon, MO
Licensed Practical Nurse 2001003762
On August 20, 2013, Respondent pled guilty to the class C felony of stealing a controlled substance.
Probation 07/09/2014 to 07/09/2019

Shepard, Jacob Charles
Saint Louis, MO
Registered Nurse 2009022691
On November 11, 2011, Respondent withdrew a five milligram vial of morphine for a patient. Respondent administered two mg of the morphine vial to the patient. Respondent was then observed going into the restroom for 15-30 minutes. When Respondent exited the restroom, his pupils were dilated and he seemed impaired. Respondent was then asked to submit to a for-cause drug screen, which he agreed to submit to. Respondent then admitted diverting morphine and Fentanyl from his employer for approximately two months by administering part of the medication to his patients and then consuming the remaining portions of the medication rather than wasting during the early months of 2011. He then stopped diverting, but then started diverting again for personal consumption in November 2011. November 11, 2011, was the third day that he had relapsed. Respondent stated he usually injected the diverted morphine and Fentanyl at home but on this occasion injected himself while working.
Probation 07/09/2014 to 07/09/2019

Owens, Brandon Timothy
Marissa, IL
Registered Nurse 2013033904
On December 31, 2013, another nurse received a "reminder" on her computer to review the effectiveness of Fentanyl to a patient that the nurse knew she had not given Fentanyl. An investigation ensued in which licensee was confronted, and licensee admitted he had taken and diverted Fentanyl to himself for his own use. Licensee was asked to complete a drug screen. The results of the drug screen on Licensee showed a positive result for Amphetamines. Licensee also in a sworn statement to the Board's investigator on March 4, 2014 admitted therein he had "taken 250 micrograms of Fentanyl on two prior occasions."
Probation 06/03/2014 to 06/03/2019

Tiethoff, Tanya Renae
Shawnee Mission, KS
Registered Nurse 2006019227
On several occasions, Licensee failed to visit the patient assigned to her, but documented that she had done so. In particular, Licensee documented that she visited the following patients on the following dates:
A.B., on October 24, 2012; A.G., on October 23, 2012; M.L., on October 24, 2012; P.L., on November 13, 2012; and C.T., on November 21, 2012. Licensee made none of these patient visits.

PROBATION continued...

Facility terminated Tiethoff's employment on December 4, 2012, for falsification of records in connection with the conduct described above.
Probation 07/11/2014 to 07/11/2015

Irwin, Jason E.
Windsor, MO
Licensed Practical Nurse 052533
On March 14, 2013, licensee received an employee counseling notice for failure to perform his responsibilities as a nurse in failing to complete weekly skin assessments on residents as required. On August 14, 2013, licensee withheld the administration of lantus insulin to resident ML for four days before ML was otherwise discovered by another staff member to have an extremely high blood sugar reading, on August 18, 2013. Licensee did so in violation of physician's orders for ML. On September 11, 2013, licensee failed to properly assess, notify the primary care physician, or verify medication orders on resident RM when she returned from the hospital. Instead, licensee instructed CNA's to simply put resident RM to bed and took no further action. On September 11, 2013, another resident, CP, was found outside lying face down on the ground. Licensee, after going outside and seeing CP on the ground, failed to properly assess CP and in fact returned to the building. Licensee also allowed six (6) other residents to get out of the building while going out to look at resident CP. Licensee instructed CNA's to simply put resident CP in a wheelchair without assessing CP's range of motion or injuries. Licensee then allowed CP to sit at the nurse's station for over an hour before CP was put to bed, still without performing any type of assessment to ensure CP did not have any fractures, and without any neurological checks to ensure no head injury had occurred to CP.
Probation 07/31/2014 to 07/31/2017

Senciboy, Jessica Lynne
Benton, MO
Licensed Practical Nurse 2007032150
On August 15, 2012, Respondent pled guilty to the class C felony of possession of a controlled substance, in the Circuit Court of Scott County, Missouri. The controlled substance she possessed was methamphetamine.
Probation 07/16/2014 to 07/16/2019

McCoy, Lee Ann J.
Wellsville, MO
Licensed Practical Nurse 032538
Licensee's license expired on May 31, 2010. Licensee practiced nursing in Missouri without a license from June 1, 2010 to March 21, 2014.
Probation 07/09/2014 to 07/18/2014

Hamby, Michelle Lynne
Warsaw, MO
Registered Nurse 2014024586
On December 6, 2013, Licensee received a General Court-Martial for diverting hydromorphone, meperidine, Dilaudid, Demerol and Percocet from her place of employment. Licensee did not have a prescription for hydromorphone, meperidine, Dilaudid, Demerol or Percocet.
Probation 07/16/2014 to 07/16/2019

Wooliver, Melissa L.
Moscow Mills, MO
Registered Nurse 131235
On May 25, 2011, Licensee submitted a urine sample for a pre-employment drug screen. Licensee's drug screen was positive for

PROBATION continued...

methadone. Licensee admitted consuming two (2) methadone tablets she misappropriated from her sister. Licensee did not have a prescription for methadone.
Probation 07/16/2014 to 07/16/2019

McCarty, Connie Marie
Rockaway Beach, MO
Registered Nurse 2008020781
On October 1, 2013, Licensee submitted a sample for a pre-employment drug test. The facility received the results of the pre-employment drug test and Medical Review Officer's report on October 10, 2013. The test was positive for Carboxy-THC, a metabolite of marijuana.
Probation 07/17/2014 to 07/17/2019

Hendricks, Apryl L.
Kansas City, MO
Registered Nurse 114744
The Board did not receive an employer evaluation or statement of unemployment by the quarterly documentation due date of April 8, 2014. In accordance with the terms of the Order, Respondent was required to meet with representatives of the Board at such times and places as required by the Board. Respondent did not attend the meeting or contact the Board to reschedule the meeting. In accordance with the terms of the Order, Respondent was required to obtain continuing education hours covering the following categories: Medication Administration 1, Medication Administration 2 (oral, ophthalmic, optic, nasal, inhalation, topical, vaginal, and rectal medication), Medication Administration 3 (injections), and Medication Administration 4 (intravenous administration), and have the certificate of completion for all hours submitted to the Board by April 8, 2014. The Board did not receive proof of any completed hours by the documentation due date of April 8, 2014.
Probation 07/10/2014 to 07/10/2015

Russell, Brianna L.
Saint Louis, MO
Licensed Practical Nurse 2005000647
On October 20, 2012, Respondent's nursing license was suspended pursuant to 324.010 RSMo, which requires the suspension of the professional license of individuals who have failed to file state tax returns and/or pay their state tax liabilities. From January 9, 2013, through January 14, 2013, Respondent withdrew six tablets containing hydrocodone for patient PG. Respondent failed to document the administration, return, or waste of the medication. From January 1, 2013, through January 10, 2013, Respondent withdrew fifteen tablets containing Tramadol for patient JC. Respondent failed to document the administration, return, or waste of the medication. From December 4, 2012, through January 14, 2013, Respondent withdrew one hundred and ten tablets containing hydrocodone for patient HD. Respondent failed to document the administration, return, or waste of the medication. From January 8, 2013, through January 10, 2013, Respondent withdrew six tablets containing oxycodone for patient MH. Respondent failed to document the administration, return, or waste of the medication. From December 16, 2012, through December 31, 2012, Respondent withdrew twenty-one tablets containing oxycodone for patient EW. Respondent failed to document the administration, return, or waste of the medication. On January 8, 2013, patient EW had an order to receive one 20 mg Oxycontin tablet at 2100. Respondent withdrew the

Probation continued on page 19

Probation continued from page 18

medication, but charted it as having fallen on the floor and wasted the medication. Respondent did not get another dose and failed to administer the ordered dose of Oxycontin, a controlled substance. From January 9, 2013, through January 14, 2013, Respondent withdrew three tablets containing codeine for patient EB. Respondent charted the waste of one tablet, but Respondent failed to document the administration, return, or waste of the remaining medication. From December 27, 2012, through January 9, 2013, Respondent withdrew thirteen tablets containing hydrocodone for patient MH. Respondent failed to document the administration, return, or waste of the medication. Patient MH was discharged on January 7, 2013, but Respondent withdrew three tablets containing hydrocodone for patient MH on January 8, 2013, and January 9, 2013.
Probation 07/16/2014 to 07/16/2019

Reed, Kimberly Dawn
Wentzville, MO
Registered Nurse 2007007825
Licensee failed to arrive at work on May 27, 2012. It was discovered that Licensee had been transported to the hospital that morning after a purported suicide attempt. The police who investigated the incident in licensee's home discovered one vial of Fentanyl and one vial of Hydromorphone inside Licensee's home.
Probation 06/17/2014 to 06/17/2017

Cordsmeyer, Rebecca Jill
Saint Thomas, MO
Licensed Practical Nurse 2011029439
On November 26, 2012, the mother of a patient, whom Respondent was caring for, reported concerns over Respondent's behaviors while at work, stating that Respondent appeared to be under the influence of drugs. On November 27, 2012, Respondent's supervisor requested Respondent submit to a for cause drug test. Respondent provided a urine sample for screening on November 29, 2012. The sample that Respondent submitted tested positive for hydrocodone and marijuana. Respondent had a prescription for hydrocodone.
Probation 07/16/2014 to 07/16/2019

Scorfina, Anthony J.
Ballwin, MO
Registered Nurse 152283
On July 16, 2001, Respondent pled guilty to the class D felony of driving while intoxicated, persistent offender, in the Circuit Court of St. Charles County, Missouri. On April 16, 2002, Respondent pled guilty to the class A misdemeanor of assault in the third degree and to the class A misdemeanor of resisting/interfering with arrest, detention or stop in the Circuit Court of St. Louis County, Missouri. On July 25, 2008, Respondent pled guilty to the class A misdemeanor of driving while intoxicated, prior offender, in the Circuit Court of St. Louis County, Missouri. Respondent failed to report any of his pleas of guilty on his applications or petitions for renewal in 2003, 2005, 2007, 2009, and 2011.
Probation 07/16/2014 to 07/16/2017

Dunwald, Bobbi Jo
Jackson, MO
Registered Nurse 2008020171
On February 4, 2013, Respondent pled guilty to the class C felony of possession of a controlled substance, in the Circuit Court of Cape Girardeau County, Missouri. Respondent possessed Hydrocodone, a controlled substance, without a lawful prescription.

PROBATION continued...

Probation 07/16/2014 to 07/16/2019

Russell, Toshia Jeanette
Kennett, MO
Licensed Practical Nurse 2009032189
On June 23, 2011, Respondent pled guilty to the class A misdemeanor of possession of a controlled substance under 35 grams of marijuana, in the Circuit Court of Pemiscot County, Missouri. Respondent did not have a prescription for marijuana.
On January 16, 2014, Respondent pled guilty to the class A misdemeanor of passing a bad check in the Circuit Court of Butler County, Missouri.
Probation 07/09/2014 to 07/09/2015

REVOCATION

Schmid, Matthew L.
Blue Springs, MO
Registered Nurse 2001024753
The Kansas Board found that Licensee violated the Kansas Nurse Practice Act by unprofessional conduct by fraud and deceit in practicing nursing.
Revoked 07/10/2014

Perkins, Erin LeAnn
Saint Charles, MO
Registered Nurse 2011016467
From November 1, 2013, until the filing of the Probation Violation Complaint on April 29, 2014, Respondent has failed to call in to NTS on five different days. Further, on December 4, 2013, January 6, 2014, and February 7, 2014, Respondent called NTS and was advised that she had been selected to provide a urine sample for screening. Respondent failed to report to a collection site to provide the requested sample on those three different days. On February 20, 2014, Respondent reported to a collection site to provide a sample and the sample tested positive for Ethyl Glucuronide (EtG), a metabolite of alcohol. Respondent later admitted to Dr. Greg Elam of NTS in reference to this sample that she had consumed over-the-counter cough syrup before giving the sample. The Board did not receive an employer evaluation or statement of unemployment by the quarterly documentation due dates of January 6, 2014, and April 7, 2014. The Board did not receive the updated chemical dependency evaluations by the documentation due dates of January 6, 2014 and April 7, 2014. The Board did not receive the quarterly support group attendance reports by the documentation due dates of January 6, 2014 and April 7, 2014.
Revoked 07/09/2014

Gibson, Mary Elizabeth
Curryville, MO
Licensed Practical Nurse 2004025092
Licensee was required to contract with the Board approved third party administrator (TPA), currently National Toxicology Specialists, Inc. (NTS), to schedule random witnessed screening for alcohol and other drugs of abuse, within twenty (20) working days of the effective date of the Board Order. Licensee did not complete the contract process with NTS. Licensee was to submit an employer evaluation from every employer or, if Licensee was unemployed, a statement indicating the periods of unemployment. The Board did not receive an employer evaluation or statement of unemployment by the documentation due date. Licensee was required to submit a chemical dependency evaluation to the Board within six (6) weeks of the

REVOCATION continued...

effective date of the Order. The Board did not receive a thorough chemical dependency evaluation submitted on Licensee's behalf. Licensee was required to obtain continuing education hours. The Board never received proof of any completed hours.
Revoked 07/03/2014

Parks, Melissa Dawn
Rolla, MO
Licensed Practical Nurse 2006031460
Licensee was required to contract with the Board approved third-party administrator, currently National Toxicology Specialists, Inc. (NTS), and participate in random drug and alcohol screenings. Licensee was required to call a toll-free number every day to determine if she was required to submit to a test that day. Licensee failed to call in to NTS on seven (7) days. Licensee had been selected for testing on one of those days, but since she failed to call NTS, she failed to report to a collection site to provide a sample for testing. On one occasion Licensee reported to lab and submitted the required sample which showed a low creatinine reading of 14.1. A creatinine reading below 20.0 is suspicious for a diluted sample, which is deemed a failed test. Licensee was to submit an employer evaluation from every employer or, if Licensee was unemployed, a statement indicating the periods of unemployment. The Board did not receive an employer evaluation or statement of unemployment by the documentation due date. Licensee was required to submit a chemical dependency evaluation to the Board within six (6) weeks of the effective date of the Order. The Board did not receive a thorough chemical dependency evaluation submitted on Licensee's behalf.
Revoked 07/03/2014

Pelecanos, Sherri J.
Bridgeton, MO
Registered Nurse 069541
Licensee was employed by a senior services facility. On September 14, 2011, Licensee was scheduled to work the night shift at the facility and arrived to work late. Licensee's co-workers noticed that Licensee was taking frequent smoke breaks, slurring her speech, stumbling while walking, smelled of alcohol, and was unable to push the numbers in the code panel to the door. Additionally, Licensee had forgotten her badge at home and was unable to administer medicines to the patients. Licensee failed to administer medications to her patients. Around 11 p.m., one of Licensee's co-workers called the Director of Nursing at home to inform the Director of her concern that Licensee had arrived to work under the influence of alcohol. The Director arrived at the facility at around 11:20 p.m. and told Licensee that staff was concerned that she was under the influence of alcohol. Licensee admitted she had been drinking and asked for help.
Revoked 06/30/2014

Hurley, Ashley Lauren
Lawrence, KS
Licensed Practical Nurse 2003016522
Licensee was employed by a care center. A report was made to the care center that medication cards and medication destruction sheets for residents at the care center, along with empty vodka bottles, an empty needle, and a partially full bottle of liquid hydrocodone, where in a rental car the complainant returned for Licensee. The items were returned to the care center the following day. The care center administrator went through the recovered narcotics and determined them to be medication cards

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that were to be returned by the care center to the pharmacy for destruction. Licensee sent an e-mail resigning her position at the care center. When Licensee arrived at the care center to pick up her final check, Licensee admitted to the care center director of nursing that she had taken controlled substance medication that had been discontinued or left after the patient had left the facility. In a statement to the Board, Licensee admitted that she abused controlled substance pain medication.
Revoked 07/02/2014

Brunk, Rita Denise
Kahoka, MO
Licensed Practical Nurse 2008011017
Respondent did not attend the meeting or contact the Board to reschedule the meeting. Respondent failed to contract with NTS by the required due date of April 25, 2014. Respondent's license expired May 31, 2012, and remains lapsed at this time. The Board did not receive a thorough chemical dependency evaluation submitted on Respondent's behalf.
Revoked 07/07/2014

Manning, Elizabeth Erin
Kansas City, MO
Registered Nurse 2009016590
Count I
In January, 2013, a pharmacy audit began at Facility 1, which revealed that Respondent's charting of narcotics and controlled substances had discrepancies and were far outside the range of other nurses similarly situated. The audit revealed specifically that in the period from December 2, 2012 through January 20, 2013, Respondent had over fifty (50) different instances of Dilaudid being accessed under her identification that had major discrepancies. Examples of some of the fifty (50) instances with discrepancies included Respondent pulling Dilaudid from a Pyxis and wasting it instead of returning it; pulling Dilaudid for patients that were not assigned to her; pulling Dilaudid for patients that had already been discharged; and, pulling Dilaudid, but not documenting it as given. The documentation violated Facility 1's policies. Respondent was initially suspended from employment pending an investigation of whether she was diverting controlled substances. When confronted by Facility 1 officials, Respondent stated the discrepancies were due to the fact that she was pulling medications for other nurses and "just trying to help other people." Respondent denied to the officials that she had taken any medications. Respondent was terminated by Facility 1 as a result of her actions.
COUNT II
In her application to Facility 2 for a nursing position, respondent did not make any written notation of any of the facts in Count I as alleged above and while mentioning that she did work at Facility 1, only mentioned that the reason she left there was for "other opportunities." Respondent therefore made a misrepresentation and was dishonest on her written application to Facility 2. On June 11, 2013, Respondent was assigned to care for patient KT. KT was also a nurse at Facility 2. KT reported that when Respondent gave her pain medication between 10:30 and 10:45 p.m., she gave her one (1) tablet of Percocet. When KT became curious about Respondent because Respondent did not check on her the rest of the night during Respondent's shift, she asked to see her own chart. KT's chart showed that Respondent had recorded administering two (2) tablets of Percocet to KT. Thereafter, an audit began at Facility 2, which revealed that Respondent's charting of narcotics and controlled substances had discrepancies. The audit revealed there were many discrepancies with Respondent's charting and recording of medications. Those included: Respondent had a high rate of "wasting" narcotics; of pulling narcotics for patients who were not assigned to her; and, of pulling narcotics on floors of the hospital on which she was not assigned. The drugs in question included Percocet, Dilaudid, and Fentanyl. Other examples of some of the instances with discrepancies included, but were not limited to: Respondent being flagged for having a high standard deviation of her pulling of Hydromorphone; pulling a large amount of Hydromorphone in Accudose machines in six (6) different locations around the hospital; and, pulling Hydromorphone and Fentanyl but not documenting it as given and with very little wastage recorded. When confronted by Facility 2 officials, Respondent stated the discrepancies were due to the fact that she was pulling medications to assist her peers. Respondent was terminated by Facility 2 as a result of her above actions.
Revoked 06/30/2014

Steele, Rhonda K.
Kansas City, MO
Licensed Practical Nurse 045588
Respondent did not attend the meeting or contact the Board to reschedule the meeting. The Board did not receive an employer evaluation or statement of unemployment by the documentation due date of January 9, 2014. The Board did not receive a thorough chemical dependency evaluation submitted on Respondent's behalf by the documentation due date of November 20, 2013. Respondent failed to contract with NTS by the due date of November 6, 2013. The Board did not receive proof of any completed continuing education hours by the documentation due date of January 9, 2014.
Revoked 07/07/2014

Mattison, Angela Dawn
West Plains, MO
Registered Nurse 2008016672
Licensee was employed as a registered professional nurse by a medical center. On December 12, 2012, patient TB requested additional pain medication.

REVOCATION continued...

The nurse on duty checked patient TB's chart and saw that Licensee had documented giving TB Percocet recently. Patient TB denied receiving Percocet. Licensee was requested to submit to a for cause drug screen because of the missing medication. Licensee's sample returned positive for hydrocodone, hydromorphone, oxycodone, and oxymorphone. Licensee did not have a prescription or a lawful reason to possess hydrocodone, hydromorphone, oxycodone, and oxymorphone.
Revoked 06/30/2014

Henderson, Donna M.
Kansas City, MO
Licensed Practical Nurse 055663
Respondent has violated the terms of her probation by failing to call in to NTS on two (2) days, failing to report to a collection site to provide the requested sample on two (2) occasions, failing to submit an employer evaluation or statement of unemployment by the documentation due date of July 1, 2013, failing to submit a chemical dependency evaluation by the May 13, 2013 documentation due date, and failing to submit an ongoing treatment evaluation form by the due date of July 1, 2013.
Revoked 06/09/2014

Kennedy, Amanda Kay
Hartshorn, MO
Licensed Practical Nurse 2010034479
Licensee was employed as a licensed practical nurse by a health care facility. On August 13, 2011, Licensee did not remove resident A.A.'s ted hose at bedtime. On August 14, 2011, Licensee did not put resident A.A.'s ted hose on at 0600; did not remove them at 2000; and, did not administer the 0600 prescribed dosage of Levothyroxin .25 mcg. On August 13, 2011, Licensee did not apply the Calmoseptine Ointment and did not put Una boots on resident R.C. On August 14, 2011, Licensee did not apply the Calmoseptine Ointment; did not put Una boots on resident R.C.; and, did not administer Ropinirole 0.5 mg at 2100. On August 13, 2011, and August 14, 2011, Licensee did not do wound care to the coccyx; did not irrigate the catheter; or, do catheter care to resident E.C. On August 13, 2011, and August 14, 2011, Licensee did not provide oxygen as ordered and did not do the nebulizer treatment on resident R.D. On August 13, 2011, and on August 14, 2011, Licensee did not apply Calmoseptine ointment to resident J.F. On August 13, 2011, and August 14, 2011, Licensee did not provide oxygen as ordered to resident P.J. On August 13, 2011, Licensee did not put the CPAP on resident W.R. On August 13, 2011, and August 14, 2011, Licensee did not apply Nystat with calmoseptine ointment and did not remove the ted hose on resident J.S. On August 14, 2011, Licensee did not administer Jevity, Acetaminophen 325 mg, or Mirtazapine 30 mg to Resident J.S. as ordered. On August 13, 2011, and August 14, 2011, Licensee did not apply Calmoseptine ointment on resident A.S. On August 14, 2011, Licensee did not check a blood sugar reading on resident A.S. On August 14, 2011, Licensee did not put the CPAP on resident J.B. On August 14, 2011, Licensee did not apply Calmoseptine ointment to resident B.B. On August 14, 2011, Licensee did not apply Zinc Oxide to resident V.D. On August 14, 2011, Licensee did not apply Orajel to resident E.G. On August 14, 2011, Licensee did not administer Levothyroxin 50 mcg to resident R.S. On August 13, 2011, and August 14, 2011, Licensee did not apply Voltaren Gel to resident D.S. On August 14, 2011, License did not provide catheter care to resident K.S. Blood sugar levels that were done and documented did not match any of the blood sugars stored in the glucometer memory. When Licensee was terminated she did not deny the allegations and her response was "I'm sorry."
Revoked 06/30/2014

Howe, John D.
Huntsville, MO
Licensed Practical Nurse 046655
On October 11, 2011, an investigation began by Facility officials into Respondent's conduct in reference to glucose checks he had allegedly performed on residents during his night shift while working there overnight. The Facility's investigation of respondent revealed that Respondent had fallen asleep during his shift, had failed to do blood sugars on twelve (12) residents that were required; had falsified the results thereof by recording they were done when they were not; and, had administered insulin to two different residents based on the falsified results. Respondent had also failed to give a written or telephone report that morning as required and could not remember why and also clocked out an hour-and-a-half late after his shift ended but did not remember clocking out late. When confronted by Facility officials, Respondent admitted that he had fallen asleep several times on his shift there and said he did not understand why the glucose monitor did not match the glucose checks that he did. He also stated that he would not "knowingly" falsify medical documentation, but he could not remember whether he had done the checks or not. Respondent's actions violated the policies of the facility. Respondent resigned his position after being confronted by Facility officials on October 11, 2011 as a result of the above actions and conduct. Respondent was investigated by the Missouri Department of Health and Senior Services as a result of his above conduct and actions, and after the investigation was completed, placed him on an Employee Disqualification List. Respondent was placed on the Missouri Department of Health and Senior Services Employee Disqualification List as a result of his above conduct and actions on September 18, 2012, and will remain on that list for three (3) years from that date.
Revoked 07/02/2014

REVOCATION continued...

Contreras, Susan Hollister
Kansas City, MO
Registered Nurse 2010030582
A Facility patient's family notified Facility that Licensee did not make home visits on November 9, 2010 and November 11, 2010. On one of the dates in question, the patient was not home because he had a doctor's appointment. Licensee entered the dates in the Facility computer system as though she had made the two (2) visits. Licensee had no patient signed notes for the two (2) dates. In meeting with Facility's Clinical Director and Administrator, Licensee stated that she must have gotten her dates mixed up and that she did not complete the documentation in the patient's home or get the patient's signature. Facility terminated Licensee on December 14, 2010 as a result of her failure to make the two (2) visits and fraudulent entry into the computer system.
Revoked 07/02/2014

Willis, Krista Lyn
O' Fallon, MO
Licensed Practical Nurse 2000163271
Licensee was employed by a care center. On February 18, 2012, Licensee charted that she passed medications to her patients during her shift. Licensee reported that she had passed all medications and left early as she was not feeling well. Certified Medical Technician (CMT) AS was sent to check on Licensee's patients after Licensee left. CMT AS discovered loose pills and opened white pill packets in the medical cart trashcan. Unopened pill packets containing medications for the residents were also discovered. Medications were discovered in the trash.
Nurse GW assumed care for Licensee's patients when Licensee finished her shift. Nurse GW discovered that Licensee had charted the medications found in the trashcan as administered to the patients. The care center administrators determined that Licensee falsely charted that medications were administered but then threw the medications in the trash without giving them to the patients. Licensee was terminated from care center on February 19, 2012. Licensee admitted that she had pre-charted that she had administered all medications to her patients for her shift on February 18, 2012. Licensee stated that she did not actually give all the medications to her patients. Licensee stated that she did not document on the MARs that some patients failed to receive their medications. Licensee admitted that she failed to properly document medication administration to her patients on February 18, 2012. Licensee failed to inform the oncoming nurse that some of the patients had not received their medications. Licensee was placed on the Department of Health and Senior Services (DHSS) employee disqualification list (EDL) for a period of two (2) years, from September 16, 2013 through September 16, 2015.
Revoked 06/30/2014

Jones, Robin Lynn
Saint Louis, MO
Registered Nurse 2011032048
Licensee was employed by a dermatology clinic. Licensee ordered three (3) unauthorized prescriptions for herself via an E-Script program. The prescriptions were for Valtrex, Septra, and Medrol. The Medrol and Septra prescriptions were ordered with the E-Script program under Dr. WB's name without his authorization. The Valtrex prescription was ordered with the E-Script program under Dr. B's name without her authorization.
Revoked 07/03/2014

Putman, Elisabeth Ann
Platte City, MO
Registered Nurse 2008005331
Licensee's license was placed on probation for a period of five (5) years beginning January 13, 2014. In accordance with the terms of the Order, within twenty (20) working days of the effective date of the Order, Licensee was required to contract with the Board approved third party administrator (TPA), currently National Toxicology Specialists, Inc. (NTS), to schedule random witnessed screenings for alcohol and other drugs of abuse. Licensee did not complete the contract process with NTS. Licensee was also required to submit a chemical dependency evaluation. The Board did not receive a thorough chemical dependency evaluation. Licensee was also required submit an employer evaluation from every employer or, if Respondent was unemployed, a statement indicating the periods of unemployment. The Board did not receive an employer evaluation or statement of unemployment.
Revoked 06/30/2014

Stone, Keisha Anedi
Saint Louis, MO
Registered Nurse 2004006343
At all times relevant herein, Licensee and her husband were co-owners of a company that provided in-home services such as skilled nursing, personal care and housekeeping. Licensee devised a scheme to obtain Medicare reimbursement for in-home services that were not rendered. In addition, Licensee and her company submitted false writings in documents presented to Medicare to receive reimbursement. On May 4, 2011, Respondent pled guilty in the United States District Court, Eastern District of Missouri to one count of health care fraud and to four (4) counts of false statements relating to health care matters. On August 31, 2011, she was sentenced to a probation term of five (5) years.
Revoked 06/30/2014

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Revocation continued from page 20

Adams, Krystal Renee
Odessa, MO
Licensed Practical Nurse 2001027608
Licensee was required to contract with the Board approved third-party administrator, currently National Toxicology Specialists, Inc. (NTS), to participate in random drug and alcohol testing. Licensee did not contact or complete the contract with NTS. In accordance with the terms of the Order, Licensee was required to obtain continuing education hours. The Board did not receive proof of any completed hours. Licensee was additionally required to submit an employer evaluation or statement of unemployment if she was unemployed. The Board did not receive an employer evaluation or statement of unemployment.
Revoked 07/03/2014

Larkin, Christine Ann
Kansas City, KS
Licensed Practical Nurse 045845
While employed as an LPN at a nursing and rehab center, on or about March 26, 2010, Licensee signed out an Oxycodone on the Controlled Substance Use Record and documented that she administered the medication to the patient at midnight. The medication did not arrive at the facility until 1:40 a.m. On or about March 27, 2010, Licensee documented that she administered Oxycodone at 0800, 1200, and 1400 when physician orders were for medication at 8:00 a.m. and 8:00 p.m. On or about March 27, 2010, Licensee documented an unwitnessed wasted dose at 1300 of oxycodone. On or about September 24, 2008, Licensee signed before a notary her "LPN Petition for License Renewal" to the Board and, upon her oath, swore that all the information in the Petition was "true to the best of my knowledge." Licensee submitted her LPN Petition for License Renewal to the Board and the Board stamped as "received" on October 3, 2008. The LPN Petition for License Renewal included the following question to which Licensee responded "No:" Question 6 asked, "Have you ever been convicted, adjudged guilty by a court, pled guilty or pled nolo contendere to any crime whether or not sentence was imposed (excluding traffic violations?)" Licensee's response to question #6 on her LPN Petition for License Renewal was not true and accurate. At the time Licensee completed her LPN Petition for License Renewal, Licensee had been "convicted, adjudged guilty by a court, pled guilty or pled nolo contendere" to the following crimes: On December 15, 2005, Licensee pled guilty to Passing Bad Checks-Less than $500, a class A misdemeanor, and was sentenced to 60 days incarceration. On February 16, 2002, Licensee was found guilty of passing a bad check (less than $500), a class A misdemeanor, and sentenced to time served and to pay restitution of $355.07. On July 27, 2006, Licensee pled no contest and was found guilty of Class A misdemeanor theft, and sentenced to jail for 270 days, followed by 10 months' probation. On June 9, 2010, Licensee stipulated to violation of probation and probation was reinstated for 12 months. Licensee served 98 days at Johnson County Residential Center from July 20, 2010, to October 26, 2010, due to probation violations. On February 28, 2007, Licensee plead guilty to theft/stealing (Value of property or Services is $500 or More but less than $25,000), a class C felony, with a suspended imposition of sentence. On July 10, 2008, Licensee's probation was revoked and she was

REVOCATION continued...

sentenced to two years' incarceration beginning on July 10, 2008, with her sentence to run concurrently with Case number 06CY-CR01524-01. Licensee completed a two-week inpatient substance abuse program from April 12-April 26, 2010. On March 22, 2007, Licensee plead guilty to Attempted Theft/Stealing, and was sentenced to three years' incarceration with a suspended execution of sentence. On May 6, 2008 Licensee's probation was revoked due to her committing the Oklahoma misdemeanor offense of obtaining merchandise by means of a bogus check.
Revoked 06/30/2014

Kirkland, Kim Michele
Centerville, IA
Registered Nurse 109511
On June 29, 2000, Licensee pled guilty to theft, first degree (a class "C" felony), in the District Court of Clark County, Iowa for misappropriation of funds from a home health agency. During 1998 and 1999 while employed as administrator and staff nurse in a rural home health care agency, Licensee misappropriated a minimum of $24,800.00 in fees paid by clients for services provided by the agency. Based upon her conduct, Licensee's Iowa Nursing license number P13056 was disciplined by the Iowa State Board of Nursing by placing it on probation from December 4, 2002 to December 4, 2003. Licensee failed to disclose her criminal guilty plea or the fact that she had been disciplined by the State of Iowa on her Application to Renew her Registered Nursing License submitted to the Missouri State Board of Nursing. Licensee additionally failed to disclose her plea of guilty or the Iowa discipline on the RN Petition for License Renewal submitted to the Board.
Revoked 07/02/2014

Johnston-Clary, Chelsea Marie
Republic, MO
Registered Nurse 2013002075
Licensee violated her probation with the Missouri State Board of Nursing by failing to call in to the Board's approved third-party drug and alcohol screenings administrator (NTS) on fifteen (15) days. Licensee ceased calling NTS on May 16, 2014. Further, on nine occasions, Licensee called NTS and was advised that she had been selected to provide a urine sample for screening. Licensee failed to report to a collection site to provide the requested sample on each of those dates. The Board did not receive an employer evaluation or statement of unemployment by the documentation due date. Licensee was employed at a mental health facility from March 4, 2013, until she was terminated on December 13, 2013. Licensee was terminated from the facility due to the refusal, inability, or unwillingness to carry out a directive, request, policy, procedure, or job expectation.
Revoked 07/02/2014

Irwin, Desiree
Kansas City, MO
Licensed Practical Nurse 2010005318
Licensee was caring for a non-verbal, medically fragile pediatric patient (K.K.) and an insulin-dependent diabetic whose blood glucose levels can quickly and unexpectedly rise very high or drop very low. The physician's orders in place for K.K. directed that if her blood glucose level was 200 or higher, she was to

REVOCATION continued...

be given a correction dose of insulin (in a specified amount, depending on the level) to lower it. Licensee tested K.K.'s blood sugar three times during her shift. At 0000 hours K.K.'s blood sugar was 500. At 0200 hours and 0400 hours, K.K.'s blood sugar was over 500 both times. Licensee "assumed" this was not an emergent situation; thus, took no corrective actions nor attempted to seek assistance in dealing with the pump even though the alarm on the pump had been sounding throughout the night from at least midnight through 6:00 a.m. and the patient had now missed two (2) prescribed doses of insulin and had elevated blood sugar levels.
Revoked 07/02/2014

Noonan, Sandra Ellen
Longmont, CO
Licensed Practical Nurse 2005025821
Resident F, who Respondent was responsible for, was found on the floor beside his bed on August 23, 2012, while respondent was on duty. Respondent was called to F's room and noticed blood on the floor that had apparently come from resident F. Respondent did not report the fall to the Home's house supervisor, did not fill out an incident report, did not assess resident F correctly after a fall, and did not document resident F's fall, all of which were in violation of the Home's policies. Respondent admitted to the Home and the Board's investigator that she did not report the fall to her house supervisor and to not do so was a mistake. Respondent resigned from the Home on August 29, 2012.
Revoked 06/30/2014

Williams, Jerrica Joyce
Kansas City, MO
Licensed Practical Nurse 2006036039
Licensee was required to contract with the Board's approved third-party administrator, currently National Toxicology Specialists, Inc. (NTS), and participate in random drug and alcohol screenings. Pursuant to that contract, Licensee was required to call a toll free number every day to determine if she was required to submit to a test that day. If selected, Licensee was required to report to a collection site and provide a sample for screening the same day of selection. From Licensee's last appearance before the Board September 5, 2013, until the filing of the complaint on April 24, 2014, Licensee reported to the lab on three (3) occasions to provide a sample for screening and each sample had a low creatinine reading. Licensee was to submit an employer evaluation from every employer or, if Licensee was unemployed, a statement indicating the periods of unemployment. The Board did not receive an employer evaluation or statement of unemployment by the documentation due dates. Licensee was required to obtain continuing education hours. The Board has not received proof of any completed continuing education hours.
Revoked 07/02/2014

Farmer, Melissa Beth
Saint Joseph, MO
Licensed Practical Nurse 2002022370
On August 2, 2011, Licensee pled guilty to the class A

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misdemeanor of Possession of up to 35 Grams Marijuana in the Circuit Court of Platte County, Missouri. On August 2, 2011, Licensee pled guilty to the class A misdemeanor of Unlawful Use of Drug Paraphernalia in the Circuit Court of Platte County, Missouri.
Revoked 07/02/2014

Ritz-Benedict, Joy L.
Hallsville, MO
Licensed Practical Nurse 041290
Licensee was employed as a licensed practical nurse by a rehab and skilled nursing facility. The facility discovered that a card of 51 tablets of Narco and the medication sign-out sheet belonging to patient M.P. were missing. Licensee was placed on the Missouri Department of Health and Senior Services Employee Disqualification List for a period of ten (10) years, effective July 18, 2012.
Revoked 07/03/2014

SUSPENSION/PROBATION

Roberts, Amy Lea
Richmond, MO
Licensed Practical Nurse 2008031826
On September 21, 2012, Respondent pled guilty to four counts of theft/stealing of a controlled substance in the Circuit Court of Ray County, Missouri, in case number 12RY-CR00110-01. The facts supporting the pleas of guilty were that Respondent diverted and consumed the controlled substances of Percocet and Vicodin from the Rehab Center where she was employed. On November 8, 2013, the Ray County Circuit Court entered a finding that Respondent had violated the terms and conditions of her probation by using methamphetamine and by failing to abide by the expectations of the Eighth Circuit Drug Court. The Court continued her probation and ordered her to enter and complete the institutional treatment program in the Missouri Department of Corrections.
Suspension 07/10/2014 to 07/10/2017; Probation 7/11/20107 to 7/11/2022

Welling, Cody Renee'
Utica, MO
Licensed Practical Nurse 2002023782
Respondent had been terminated from employment as an LPN as a result of her diversion of the controlled substances of Norco (Hydrocodone) and Vicodin captured by video surveillance in the Center's medication room on May 14, 2013. The Center called the police and Respondent was arrested. Respondent admitted to the police that she had taken the Norco and the Vicodin from the Center. She also told them that she had taken pills from the Center approximately fifteen to twenty (15-20) times and that such activity began in March, 2013, when she began employment at the Center. On October 8, 2013, Respondent pled guilty to one count of Attempted Theft/ Stealing Any Controlled Substance, a felony, as a result of her conduct in the above incident at the Center. When Respondent was interviewed by the Board's investigator on June 8, 2013, about the above incident, Respondent stated: "I'm guilty as charged. I'm in treatment and waiting for the criminal court decision to send my statement." In addition, the Board was informed on or about January 9, 2014, that Respondent had been placed on the Missouri Health Employer's Disqualification List effective November 18, 2013 as a result of the above incident, for a period of five years. Respondent admitted that she diverted hydrocodone and Vicodin and stated that she would substitute Extra Strength Tylenol and give that to the patient instead of the controlled substance. Respondent admitted that she is not safe to practice as a nurse at this time and cannot have access to controlled substances as a condition of her criminal probation until 2018.
Suspension 07/02/2014 to 07/02/2017; Probation 7/3/2017 to 7/3/2022

SUSPENSION/PROBATION continued...

Risner, Suzanne Marie
Springfield, MO
Registered Nurse 2009003086
On February 13, 2014, supervisors and co-workers at Facility began to notice licensee acting strangely and inappropriately while on duty in many different situations. On February 13, 2014, licensee missed a staff meeting and when asked about it, was very confused and had rambling speech and appeared to be drowsy. On February 14, 2014, licensee became hostile and began yelling and cursing when asked to help distribute blankets before she could go home. On February 18, 2014, licensee's whereabouts were unknown by staff from 2348 until 0100. At 0615 when licensee was asked who the second overnight nurse was, she appeared to be drowsy, became confused and rambling, and began contradicting herself. On February 18, 2014, Facility staff reported that licensee frequently digs in the trash by the anesthesia machines and retrieves the bags in which drugs are delivered. When questioned, licensee reported she was collecting them for a "friend." Based on her above conduct, licensee was requested to submit to a for-cause drug test. Licensee tested positive for Methamphetamine. Licensee admitted to the Board's investigator that she had ingested a "compound" a friend had made for her that was supposed to be a diet pill with an energy supplement.
Suspension 08/21/2014 to 02/21/2015; Probation 2/22/2015 to 2/22/2020

Frame, Timothy Kirk
Kansas City, MO
Registered Nurse 2004019611
Facility employees began to notice discrepancies in licensee's administration and wasting of controlled substances during July, 2013. The facility's pharmacy began an investigation into licensee's activities, and in analyzing his activities between July 26, 2013 and August 15, 2013, found substantial discrepancies in licensee's practice, including improper wastage of several controlled substances with no explanation as to why controlled substances were either not administered or returned to the system. The medication unaccounted for included a total of 10 mg/ml of Morphine, 100mcg/ml of Fentanyl, and 2 mg/ml of Midazolam. Licensee was therefore asked by Facility to submit to a for-cause drug test. The test was positive for Fentanyl. Licensee did not have a prescription for, or a lawful reason to possess, Fentanyl. Licensee later stated that he had cut his finger on a broken vial of Fentanyl. Licensee's actions violated Facility's policies. Licensee's employment was terminated by Facility.
Suspension 08/21/2014 to 02/21/2015; Probation 2/22/2015 to 2/22/2020

Chilton, Kristen Rachelle
Van Buren, MO
Registered Nurse 2005021021
From the start of Respondent's probation through May 5, 2014, Respondent failed to call in to NTS on fifty (50) days. Respondent has not called NTS since March 16, 2014. Respondent failed to report to a collection site to provide a sample for testing on March 28, 2014; April 16, 2014; and April 23, 2014. On Mach 10, 2014, Respondent submitted a urine sample for random drug screening. That sample tested positive for the presence of Amphetamine and Methamphetamine. The Board did not receive an employer evaluation or statement of unemployment by the documentation due date of April 23, 2014. The Board did not receive a thorough chemical dependency evaluation submitted on Respondent's behalf by the March 6, 2014 due date. The Board did not receive proof of completed continuing education hours covering the required courses by the April 23, 2014 due date. On March 1, 2014, while Respondent was on duty as a nurse, Center administrator's received reports that Respondent was displaying odd behavior and was acting impaired. On March 1, 2014, Respondent submitted a sample for the requested drug screen and tested positive for amphetamines and methamphetamines.
Suspension 07/02/2014 to 07/02/2017; Probation 7/3/3017 to 7/3/2022

SUSPENSION

Brown, Emily Suzanne
East Prairie, MO
Licensed Practical Nurse 2010031173
Licensee failed to call NTS on at least four (4) occasions; failed to provide a sample for drug and alcohol screening on two occasions; and, ingested Tramadol.
Suspension 08/27/2014 to 08/31/2014

VOLUNTARY SURRENDER

Kaufman, Laura J.
Saint Louis, MO
Registered Nurse 086016
Licensee Surrendered her license on June 30, 2014.
Voluntary Surrender 06/30/2014

Michael, Sarah Jayne
Kansas City, MO
Licensed Practical Nurse 2014001333
Licensee Voluntarily Surrendered her license on June 30, 2014.
Voluntary Surrender 06/30/2014

May, Teri S.
Joplin, MO
Registered Nurse 133174
On May 1, 2013, the Arkansas State Board of Nursing issued a Cease and Desist Order to Licensee ordering Licensee to cease practicing nursing in the State of Arkansas under her privilege to practice, finding that: "On or about February 22, 2013, an Arkansas employer reported Licensee's termination on or about January 24, 2013, after a for-cause drug screen was positive for Morphine, Fentanyl, Norfentanyl, and Tramadol. In a statement dated April 18, 2013, Licensee also admitted to taking a relative's Hydrocodone and Oxycodone." Licensee admitted to the Arkansas Board of Nursing that in August 2011, she started abusing intra venous (IV) narcotics by using narcotics that should have been wasted and then replaced the waste with saline. Licensee further admitted that she used fentanyl and morphine while working on January 24, 2013 and admitted to taking a relative's prescription hydrocodone and oxycodone. Licensee admitted the Missouri State Board of Nursing that she abused IV narcotics on several occasions since August 2011 and that she additionally consumed a relative's prescription hydrocodone and Percocet that the relative no longer took.
Voluntary Surrender 06/17/2014

Kellerman, Virginia L.
Pilot Grove, MO
Registered Nurse 145077
Licensee Voluntarily Surrendered her license on 6/30/2014.
Voluntary Surrender 06/30/2014

Wineland, Trenda Gail
Kansas City, MO
Registered Nurse 2009004010
Licensee was employed as a registered nurse at a hospital and was terminated on April 5, 2013, for the diversion of controlled substances. A review of Licensee's narcotic activity from March 1, 2013 through April 5, 2013, showed several discrepancies in the timing of the narcotic administration; wasted narcotics; failing to document wasted narcotics; and a difference in the frequency in which Licensee provided narcotics to patients compared to the frequency that other nurses provided narcotics to patients. It was also discovered that Licensee was the highest dispenser of several narcotics compared to her co-workers. When Licensee was questioned about the results of the audit, she initially stated that she did not know how it could have happened. Licensee then admitted to diverting narcotics for her own personal use. Licensee had seven (7) vials of narcotics, a hypodermic needle, and a syringe with the needle still attached

Voluntary Surrender continued on page 23

Voluntary Surrender continued from page 22

with blood present in the needle cap, indicating usage, in her pocket when confronted by hospital administration on April 5, 2013.
Voluntary Surrender 07/01/2014

Combs, Lisa G.
Troy, MO
Licensed Practical Nurse 056703
Licensee surrendered her license.
Voluntary Surrender 08/26/2014

Goodhart, Angelia S.
Hannibal, MO
Licensed Practical Nurse 2003022445
Licensee voluntarily surrendered her license
Voluntary Surrender 08/18/2014

Hayes, Judith A.
Florissant, MO
Registered Nurse 059407
Licensee did not administer full resuscitation measures in accordance with policy to a patient and voluntarily surrendered her license.
Voluntary Surrender 08/21/2014

Hacker, Paula J.
Diamond, MO
Registered Nurse 113951
On March 28, 2014, patient A. B. was admitted to the behavioral health unit at the hospital. A. B. had eleven (11) hospitalizations with the hospital over the past thirteen (13) months. Licensee met A.B. when A.B. was hospitalized at the hospital during Licensee's employment with the hospital. During her admission process on March 28, 2014, patient A. B. stated that she was concerned about getting her belongings back from the house she had been staying at. Patient A. B. then explained that she had been staying with Licensee for the past six (6) months until Licensee "kicked her out." Patient A. B. stated that she overdosed on Tylenol when Licensee told her to get out. Licensee drove patient A. B. to the emergency room. In October 2013, there was an incident where Patient A. B. called Licensee at work in the middle of night. Patient A. B. was in a crisis situation. When asked why the phone number caller ID showed Licensee's name by the manager of the unit, Licensee explained that Patient A. B. was attending Licensee's church and was friends with her daughter and sometimes Licensee allowed patient A. B. to use her cell phone. It was explained to Licensee at that time that Licensee needed to be careful with boundaries and understand the professional boundaries that are expected. Licensee allowed A.B. to manipulate Licensee into living with Licensee, which crossed professional boundaries.
Voluntary Surrender 08/15/2014

Clack, Dale M.
Jefferson City, MO
Registered Nurse 137152
On October 18, 2013, Licensee submitted a sample for a pre-employment drug test. The test was positive for THC, a metabolite of marijuana. Licensee did not have a prescription for, or a lawful reason to possess, marijuana.
Voluntary Surrender 07/22/2014

Halbert, Alisha Louise
Yukon, OK
Registered Nurse 2013042897
On June 9, 2014, Licensee Voluntarily Surrendered her Missouri Nursing License.
Voluntary Surrender 06/09/2014

NOTIFICATION OF NAME AND/OR ADDRESS CHANGE

☐ NAME ☐ ADDRESS ☐ PHONE ☐ ALTERNATE PHONE ☐ EMail

☐ RN ☐ APRN ☐ LPN

Missouri License Number _____ Social Security Number _____

NAME AS CURRENTLY IN OUR SYSTEM

Last Name (Printed) _____ First Name (Printed) _____

NEW INFORMATION

Last Name _____ First Name _____ Middle Name _____

(_____)_____ (_____)_____ _____
Daytime Telephone Number Alternate Phone Number E-mail Address

PRIMARY STATE OF RESIDENCE ADDRESS: (where you vote, pay federal taxes, obtain a driver's license)

Physical address required, **PO boxes are not acceptable**

CITY STATE ZIP

MAILING ADDRESS (ONLY REQUIRED IF YOUR MAILING ADDRESS IS DIFFERENT THAN PRIMARY RESIDENCE)

STREET OR PO BOX

CITY STATE ZIP

☐ I declare _____ as my primary state of residence effective _____.
(primary state of residence) (effective date)

☐ I am employed exclusively in the U.S. Military (Active Duty) or with the U.S. Federal Government and am requesting a Missouri single-state license regardless of my primary state of residence.

Information on the Nurse Licensure Compact can be found at www.ncsbn.org/nlc.htm
In accordance with the Nurse Licensure Compact **"Primary State of Residence"** is defined as the state of a person's declared fixed, permanent and principal home for legal purposes; domicile. Documentation of primary state of residence that may be requested (but not limited to) includes:

- Driver's license with a home address
- Voter registration card displaying a home address
- Federal income tax return declaring the primary state of residence
- Military Form no. 2058 – state of legal residence certificate
- W-2 from US Government or any bureau, division or agency thereof indicating the declared state of residence

Proof of any of the above may be requested.

When your primary state of residence is a non-compact state, your license will be designated as a single-state license valid only in Missouri.

When your primary state of residence is a compact state other than Missouri, your Missouri license will be placed on inactive status and you can practice in Missouri based on your unrestricted multi-state license from another compact state.

I solemnly declare and affirm, that I am the person who is referred to in the foregoing declaration of primary state of residence; that the statements therein are strictly true in every respect, under the pains and penalties of perjury.

→ _____ _____
Signature ***(This form must be signed)*** Date

Complete, SIGN and Return to the Missouri State Board of Nursing, PO Box 656, Jefferson City, MO 65102 Or Fax to 573-751-6745 or Scan and Email to nursing@pr.mo.gov